IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON– Director

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BUREAU OF FACILITY STANDARDS
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August 3, 2018

John Schulkins, Administrator
Canyon West of Cascadia
2814 South Indiana Avenue
Caldwell, ID 83605-5925

Provider #: 135051

Dear Mr. Schulkins:

On **July 13, 2018**, a survey was conducted at Canyon West of Cascadia 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 an isolated deficiency that constitutes actual harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. 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.) **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 **August 13, 2018.** Failure to submit an acceptable PoC by **August 13, 2018**, may result in the imposition of civil monetary penalties by **September 5, 2018**.

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*.

Your facility's noncompliance with the following:

- **F0883 -- S/S: F -- 483.80(d)(1)(2) -- Influenza And Pneumococcal Immunizations**

has been determined to constitute substandard quality of care (SQC) as defined at 42 CFR §488.301. Sections 1819 (g)(5)(c) and 1919 (g)(5)(c) of the Social Security Act and 42 CFR §488.325 (h) requires the attending physician of each resident who was found to have received substandard quality of care, as well as the state board responsible for licensing the facility's administrator be notified of the substandard quality of care.

In order for us to satisfy these notification requirements, and in accordance with 42 CFR §488.325(g), you are required to provide the following information to this agency within ten (10) working days of your receipt of this letter:

The name and address of the attending physician of each resident found to have received substandard quality of care, as identified below:

Residents #**2, #20, #52 and #17** as identified on the enclosed Resident Identifier List.

Please note that in accordance with 42 CFR §488.325(g), your failure to provide this information timely will result in termination of participation or imposition of additional remedies.

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

- **Civil Money Penalty**
- **Denial of payment for new admissions effective October 13, 2018.**

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **January 13, 2019**, 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 Debby Ransom, RN, RHIT, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 5; 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.

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 **August 13, 2018**. If your request for informal dispute resolution is received after **August 13, 2018**, 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 Debby Ransom, RN, RHIT, Bureau Chief at (208) 334-6626, option 5.

Sincerely,

Debby Ransom, RN, RHIT, Chief
Bureau of Facility Standards

DR/lj

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135051		07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON WEST OF CASCADIA	2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
	The following deficiencies were cited during the federal recertification and complaint survey conducted July 9, 2018 to July 13, 2018. The surveyors conducting the survey were: Jenny Walker, RN, Team Coordinator Teresa Kobza, RD Teri Hobson, RN Presie Billington, RN ABBREVIATIONS: ADL = Activity of Daily Living CNA = Certified Nursing Assistant DNS = Director of Nursing LPN = Licensed Practical Nurse MAR = Medication Administration record MDS = Minimum Data Set PROM = Passive Range of Motion RN = Registered Nurse RNA = Restorative Nursing Assistant ROM = Range of Motion TAR = Treatment Administration Record			
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff	F 558	This Plan of Correction is prepared and	8/30/18

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

Electronically Signed — 08/13/2018

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 558	Continued From page 1 interview, it was determined the facility failed to ensure residents call lights were within reach for 2 of 18 (#20 and #24) residents sampled for call lights. This deficient practice had the potential to cause harm if the resident could not request assistance when needed or experienced an adverse medical event requiring prompt staff attention. Findings include: 1. Resident #20 was readmitted to the facility on 12/27/15, with diagnoses which included dementia without behavioral disturbances. A quarterly MDS assessment, dated 5/7/18, documented Resident #20 had a severe cognitive impairment. The MDS assessment documented she was totally dependent or required extensive assistance of 1 to 2 staff members with all cares except eating. On 7/9/18 at 2:34 PM, Resident #20 was observed in bed and her call light was hanging on the bedside table approximately 3 feet from her reach. On 7/9/18 at 2:41 PM, CNA #1 stated Resident #20's call light was not within her reach and she moved the call light onto Resident #20's bed. CNA #1 stated call lights should be within residents' reach to call for assistance. 2. Resident #24 was readmitted to the facility on 9/27/17, with diagnoses which included Parkinson's disease, contracture to the left knee, left hip, right hip, right knee, and multiple sclerosis. A quarterly MDS assessment, dated 5/11/18,	F 558	submitted as required by law. By submitting this Plan of Correction, Canyon West of Cascadia does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. Resident Specific The ID team reviewed resident #20 and 24 to validate call lights were accessible while in bed or when returning to their rooms. Adjustments have been made as indicated. Other Residents The ID team rounds include review of other residents for call lights being within reach while in their rooms or accessible upon returning to their rooms. Adjustments have been made as indicated. Facility Systems Staff are educated to have call lights accessible while in bed or upon returning their rooms. Re-education was provided by the Chief Nursing Officer to include but not limited to, placing call lights within reach of residents when in their room and accessible upon returning to their rooms. The system is amended to include review of call light availability on department	

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F 558	Continued From page 2 documented Resident #24 had a moderate cognitive impairment. The MDS documented she was totally dependent on 1 to 2 staff members with all cares. On 7/11/18 at 9:20 AM, Resident #24's call light was observed on the end of her bed hooked onto blankets. Resident #24 was positioned in her wheelchair approximately 6 feet away from her call light. On 7/11/18 at 9:33 AM, CNA #2 stated Resident #24's call light was not within reach and she moved it onto Resident #24. CNA #2 stated the purpose of a call light was for alerting staff of residents' needs. On 7/12/18 at 10:51 AM, the DNS stated call lights were used to alert staff when residents needed assistance and call lights should be within reach.	F 558	manager rounds. Monitor The Chief Nursing Officer and/or designee will audit 5 residents for call lights being within reach of residents weekly for 4 weeks, then 2 residents weekly for 8 weeks. Starting the week of August 30, 2018, the review will be documented on the QAPI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.	
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral	F 622		8/30/18

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F 622	Continued From page 3 status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include:	F 622		

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F 622	Continued From page 4 (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, policy review and record review, it was determined the facility failed to ensure all transfer information was provided to the receiving facility and documented in the resident's record for 1 of 1 resident (#55) reviewed for transfer. The deficient practice had	F 622	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Canyon West of Cascadia does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility	

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F 622	Continued From page 5 the potential to cause harm if the resident was not treated in a timely manner due to lack of information provided upon transfer. Findings include: A facility transfer & discharge policy dated 11/28/17, documented the facility was to send the following information with the resident for transfer to the receiving facility: * A copy of the physician's contact information, representative contact information, and advanced directives. * Special instructions for ongoing care such as treatments and devices, (i.e. oxygen, implants, IV's, tubes, or catheters). * Documentation of precautions, and special risks (i.e. falls, elopement, bleeding, or pressure injury). * A copy of the comprehensive care plan and goals. * A copy of diagnoses, allergies, medications, recent labs, other diagnostic testing, and recent immunizations. Resident #55 was admitted to the facility on 4/16/18, with diagnoses including multiple neck fractures, stroke, legal blindness, and multiple site contractures. Resident #55 was transferred to the hospital on 6/2/18. A physician's order dated 6/2/18, documented Resident #55 was ordered to be sent to the ER with complaints of nausea, vomiting and	F 622	admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. Resident Specific As noted in the CMS-2567, resident #55 was discharged Other Residents The clinical management team reviewed other residents with anticipated discharge to validate written documents are prepared and provided upon discharge to the receiving facility. A copy of the discharge documents are included in the closed records. Adjustments have been made as indicated. Facility Systems Licensed staff are educated to communicate pertinent information to the receiving facility upon resident transfer. Re-education was provided by the Chief Nursing Officer to include but not limited to, sending the following information with the resident for transfer to the receiving facility: reason for transfer, a copy of the physician’s contact information, resident representative contact information, advance directives, special instructions for ongoing care as noted in the physician orders to include allergies, care plan goals as indicated; and other baseline	

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F 622	Continued From page 6 abdominal pain. A progress note dated 6/2/18, documented Resident #55 was sent to the ER via ambulance. The progress note did not document if written documents were given to the ambulance personnel or a written, verbal, or faxed report was provided to the hospital staff. On 7/13/18 at 8:29 AM, the DNS stated the facility did not have a discharge/transfer form. She stated the facility would have included a face sheet, medication list, physician orders and advanced directive with a resident for a transfer to another agency. She stated they did not have documentation of what documents were sent to the hospital with Resident #55 on 6/2/18. On 7/13/18 at 10:29 AM, the Medical Records Coordinator stated the facility did not keep copies of transfer documents in the residents' records. She stated the face sheet, diagnose list, vital signs history, medication list, advanced directives, and physician's orders were printed and sent with the resident when transferred to a physician's office or hospital.	F 622	information based upon reason for discharge. The system is amended to include maintaining a copy of the transfer record within the resident's closed medical record. Monitor The Chief Nursing Officer and/or designee will audit all resident transfer records for a copy of the transfer information weekly for 4 weeks, then 2 transfer records (if occurred) weekly for 8 weeks. Starting the week of August 30, 2018, the review will be documented on the QAPI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 656		8/30/18

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F 656	Continued From page 7 assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure residents' care plans included restorative nursing services, when needed. This was true for 3 of 3 (#17, #22, and #24) sampled residents	F 656	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Canyon West of Cascadia does not admit that the deficiencies listed on the CMS	

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F 656	Continued From page 8 reviewed for restorative nursing services. This deficient practice placed the residents at risk of decreased ROM, contracture's, or other injuries related to the lack of a restorative program. Findings include: 1. Resident #22 was readmitted to the facility on 9/1/17 with multiple diagnoses, including contracture to the left hand and dementia. A quarterly MDS assessment, dated 5/9/18, documented Resident #22 was severely cognitively impaired, required extensive assistance from two people, and had limited ROM impairments in both upper and lower extremities. Resident #22's July 2018 Physician's Medication Order Summary Report, on 4/16/17 documented, "RNA". Resident #22's care plan did not include a restorative nursing program. On 7/12/18 at 9:39 AM, LPN #2 stated Resident #22 should have had a restorative nursing care plan. 2. Resident #24 was readmitted to the facility on 9/27/17, with diagnoses which included Parkinson's disease, contracture to the left knee, left hip, right hip, right knee, and multiple sclerosis. A quarterly MDS assessment, dated 5/11/18, documented Resident #24 had a moderate cognitive impairment. The MDS assessment documented she was totally dependent on 1 to 2	F 656	Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. Resident Specific The clinical management team reviewed resident #17, 22, and 24 for restorative needs. The resident care plans have been updated to include restorative nursing services. Other Residents The clinical management team reviewed other residents for restorative nursing services. The care plans have been updated as indicated. Facility Systems Licensed nurses are educated to develop a comprehensive care plan for each resident. Re-education was provided by the Chief Nursing Officer to include but not limited to, including restorative nursing services on the resident care plan, when indicated. The system is amended to include review of residents that transfer from therapy to restorative nursing services in clinical meeting. Validation of the restorative care plan to occur as indicated, as well as review of the residents' comprehensive care with the quarterly care conference.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON WEST OF CASCADIA	2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605

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F 656	Continued From page 9 staff members for all cares. The MDS assessment documented she had bilateral functional range of motion impairments in her upper and lower extremities. The MDS assessment documented she participated in 1 day of passive range of motion and 1 day of splint/brace assistance. Resident #24's July 2018 Physician's Medication Order Summary Report documented on 4/30/18, she was to be evaluated for, and treated by, an RNA Program. Resident #24's care plan did not include a restorative nursing program. On 7/12/18 at 9:39 AM, LPN #2 was unaware Resident #24's care plan did not include a restorative nursing program. On 7/12/18 at 10:41 AM, the DNS stated Resident #24 should have a care plan for restorative nursing to include monitoring her skin under her braces at least once a day to check for signs of skin breakdown. 3. Resident #17 was admitted to the facility on 4/4/08, with diagnoses which included muscle weakness and osteoarthritis. A quarterly MDS assessment, dated 5/1/18, documented Resident #17 had a moderate cognitive impairment. The MDS assessment documented he was totally dependent on 1 to 2 staff members for all cares. The MDS assessment documented he had bilateral range of motion impairments in his upper and lower extremities. The quarterly MDS assessment,	F 656	Monitor The Chief Nursing Officer and/or designee will audit 5 resident records for validation that the restorative nursing services program is included on the care plan, weekly for 4 weeks, then 2 residents weekly for 8 weeks. Starting the week of August 30, 2018, the review will be documented on the QAPI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate. Date of Compliance August 30, 2018	

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F 656	Continued From page 10 dated 4/10/18, documented Resident #17 required extensive assistance of 1 to 2 staff members with all cares. Resident #17's care plan did not include a restorative nursing program. On 7/9/18 at 2:31 PM, Resident #17 was observed in bed with contractures at his wrists and his legs would not straighten to a 180 degree angle. Resident #17 was observed again on 7/10/18 at 10:32 AM, 10:35 AM, 10:49 AM, 1:58 PM, and on 07/12/18 at 10:17 AM with contractures. On 7/9/18 at 3:48 PM, LPN #3 stated Resident #17 should be receiving restorative nursing care for his hands because his hands had range of motion impairments. On 7/12/18 at 10:17 AM, the MDS Assistant was observed assessing Resident #17's ROM in his bilateral upper and lower extremities. The MDS Assistant stated based on her evaluation and Resident #17 being unable to straighten his wrists and his knees, her assessment was that he had bilateral upper and lower ROM impairments in his extremities. On 7/12/18 at 10:55 AM, the DNS stated when a resident had a decline in ADLs the resident should be placed on a restorative program and/or receive an evaluation from physical therapy and/or occupational therapy. The DNS said the resident would need a care plan for the services, once started.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		8/30/18

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F 657	Continued From page 11 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, it was determined the facility failed to ensure care plans were revised as residents' needs changed. This was true for 1 of 19 residents (#20) whose care plans were reviewed. The failure created the potential for harm when Resident #20's care plan was not revised to include interventions for wound management.	F 657	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Canyon West of Cascadia does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the	

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F 657	Continued From page 12 Findings include: Resident #20 was readmitted to the facility on 12/27/15, with diagnoses which included dementia without behavioral disturbances. A quarterly MDS assessment, dated 5/7/18, documented Resident #20 had a severe cognitive impairment. The MDS assessment documented she was totally dependent or required extensive assistance of 1 to 2 staff members for all cares except eating. The MDS assessment documented she had skin tears. A previous quarterly MDS assessment, dated 2/4/18, documented she had no skin tears or wounds. The care plan area addressing Resident #20's skin impairments, initiated 5/9/18, documented Resident #20 experienced skin impairments such as complications related to areas of injury to her left lower extremity abrasion, initiated 7/9/18. The care plan documented staff were to monitor and document the location, size, and treatment of skin injury and report abnormalities, failure to heal, any signs and symptoms of infections, and/or maceration (softening and breaking down of skin resulting from prolonged exposure to moisture) to the physician. The Braden Scale, dated 5/6/18, documented Resident #20 was at risk for developing pressure ulcers. A Weekly Skin Alteration Report, dated 4/30/18, documented Resident #20 had a 10 cm 1/2 moon shaped skin tear on the back of her left lower leg, first observed 4/30/18.	F 657	alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. Resident Specific The clinical management team reviewed resident #20 care plan for updates. It was revised to include wound management and directives for the use of tubi-grips. Other Residents The clinical management team reviewed other residents to validate care plans were revised to indicate the intervention for wound management and directives for the use of tubi-grips. Adjustments have been made as indicated. Facility Systems Licensed nurses are educated to revise care plans with clinical updates. Re-education was provided by Chief Nursing Officer to include but not limited to, revision of care plans for wound manage to include interventions such as tubi-grips. The system is amended to include review of order changes for wound management and care plan updates in clinical meeting. Monitor The Chief Nursing Officer and/or designee will audit 5 residents who are on wound management program and/or utilize tubi-grips to validate care plans are	

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F 657	Continued From page 13 A Weekly Skin Alteration Report, dated 7/6/18, documented Resident #20 had three wounds on her left lower leg, first observed on 4/40/18. She had one wound on the anterior (front) of her left lower leg 5 cm by 3.5 cm, a 4 cm by 2.5 cm wound on the posterior (back) of her left lower leg, and a 0.7 cm by 0.7 cm wound on her lateral (side) left lower leg. The report documented slough (dead tissue, usually cream or yellow in color) was present on the anterior and posterior wounds with odor, purulent (pus) discharge, signs and symptoms of infection, and the wound progression had deteriorated. On 7/10/18 at 2:17 PM, 6:36 PM, 7/11/18 at 9:14, 10:47, 1:54 PM, 2:06 PM, and 2:37 PM, Resident #20 was observed with Tubigrips (elastic tubular compression bandage) in place on both legs. Resident #20's care plan did not include directions to staff regarding when to apply and remove the Tubigrips, ensure the Tubigrips were functional, and to check the skin under the stockings. On 7/11/18 at 9:14 AM, the DNS and the Clinical Resource Nurse stated they had spoken with a nurse about Resident #20's Tubigrips. The DNS could not locate Resident #20's Tubigrips on the care plan.	F 657	revised as residents' needs change weekly for 4 weeks, then 2 residents weekly for 8 weeks. Starting the week of August 30, 2018, the review will be documented on the QAPI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.	
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to	F 676		8/30/18

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F 676	Continued From page 14 ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to recognize an ADL decline and implement a restorative nursing program (RNP) for 1 of 3	F 676	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Canyon West of Cascadia does not admit	

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F 676	Continued From page 15 residents (#17) reviewed for restorative nursing services. The failure created the potential harm for Resident #17 to experience a decline in ROM. Findings include: Resident #17 was admitted to the facility on 4/4/08, with diagnoses which included muscle weakness and osteoarthritis. A quarterly MDS assessment, dated 9/23/16, documented Resident #17 required extensive assistance of 1 to 2 staff members for all cares and had bilateral upper and lower ROM impairments in his extremities. A quarterly MDS assessment, dated 4/10/18, documented Resident #17 required extensive assistance of 1 to 2 staff members for all cares and was without ROM impairments. A quarterly MDS assessment, dated 5/1/18, documented Resident #17 had a moderate cognitive impairment. The MDS assessment documented he was totally dependent on 1 to 2 staff members for all cares. The MDS assessment documented he had bilateral range of motion impairments in his upper and lower extremities. Resident #17's care plan did not include a restorative nursing program. On 7/9/18 at 2:31 PM, Resident #17 was observed in bed with contractures at his wrists and his legs would not straighten to a 180 degree angle. Resident #17 was observed again on 7/10/18 at 10:32 AM, 10:35 AM, 10:49 AM, 1:58 PM, and on 07/12/18 at 10:17 AM with the	F 676	that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. Resident Specific The ID team reviewed resident #17 for restorative nursing services. A restorative nursing program is implemented as indicated. Other Residents The ID team reviewed other residents for a decline in ADLs. A restorative nursing program (RNP) is implemented as appropriate. Facility Systems Licensed nurses are educated to recognize an ADL decline. Re-education was provided by the Chief Nursing Officer to include but not limited to, recognizing an ADL decline, request orders for and implement a restorative nursing program (RNP) as appropriate. The system is amended to include review of ADL changes in restorative meetings, referral to therapy as indicated, and establishment of the restorative nursing program when appropriate. Monitor The Chief Nursing Officer and/or	

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F 676	Continued From page 16 contractures. On 7/9/18 at 3:48 PM, LPN #3 stated Resident #17 should be receiving restorative nursing for his hands because his hands had range of motion impairments. On 7/12/18 at 10:05 AM, LPN #2 stated Resident #17 was not on a RNP and Resident #17 had not had an ADL decline that required a restorative nursing program. LPN #2 stated Resident #17 did not have ROM impairments in his upper and lower extremities. LPN #2 stated she did not know how Resident #17's MDS assessment documented a decline in his ADLs. LPN #2 stated she watched Resident #17 closely. On 7/12/18 at 10:17 AM, the MDS Assistant was observed assessing Resident #17's ROM in his bilateral upper and lower extremities. The MDS Assistant stated she did not perform the assessments on 4/10/18 or 5/1/18 for Resident #17. The MDS Assistant stated based on her evaluation and Resident #17 being unable to straighten his wrists and his knees, her assessment was that he had bilateral upper and lower ROM impairments in his extremities. The MDS Assistant stated it would not hurt if Resident #17 was picked up by the RNP or therapy services. On 7/12/18 at 10:55 AM, the DNS stated when a resident had a decline in ADLs the resident should be placed on a RNP and/or receive an evaluation from physical therapy and/or occupational therapy.	F 676	designee will audit 5 residents for ADL decline and implementation of a restorative nursing program (RNP) as appropriate, weekly for 4 weeks, then 2 residents weekly for 8 weeks. Starting the week of August 30, 2018, the review will be documented on the QAPI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.	
F 677 SS=G	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		8/30/18

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F 677	Continued From page 17 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interview, it was determined the facility failed to ensure residents were provided with bathing and oral care consistent with their needs. This was true for 4 of 8 (#41, #24, #27, and #159) residents sampled for bathing, and 4 of 8 (#17, #20, #24 and #44) residents sampled for oral care. Resident # 41 experienced psychosocial harm when she had ongoing embarrassment and a decline in her feelings of self-worth after she did not consistently receive showers to prevent body odors. This failure created the potential for residents (#17, #20 #24, #27, #44, and #159) to experience embarrassment, isolation, decreased sense of self-worth, skin impairment, and compromised physical and psychosocial well-being. Findings include: 1. Resident #41 was readmitted to the facility on 6/4/18, with multiple diagnoses, which included cerebrovascular accident (stroke). Resident #41's quarterly MDS assessment, dated 5/7/18, documented her cognition was severely cognitively impaired and was totally dependent on two staff members with bathing. Resident #41's June 2018 ADLs Report documented her bathing schedule was every Monday, Wednesday, and Friday. Resident #41 did not receive a bath on 6/6/18, 6/8/18, 6/11/18,	F 677	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Canyon West of Cascadia does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. Resident Specific The ID team reviewed resident #41, 24, and 27 for bathing, and resident #17, 20, and 24 for oral care. Resident #44 and #159 discharged. Rounds reveal residents are bathed and have oral hygiene needs met. Other Residents The ID team reviewed other residents for bathing and oral care needs. Adjustments have been made as indicated. Facility Systems Licensed nurses and CNAs are educated to validate residents are provided bathing and oral care consistent with their needs.	

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F 677	Continued From page 18 6/13/18, 6/15/18, 6/18/18, 6/20/18, 6/22/18, 6/27/18, and 6/29/18. Resident #41 received 2 baths out of 11 baths scheduled for the month of June. Resident #41's July 2018 ADLs Report, documented she received 2 baths out of 4 baths scheduled from 7/1/18 to 7/9/18. On 7/10/18 at 10:34 AM, upon entering Resident #41's room, a fish like odor was noted. The odor was more pronounced closer to Resident #41's bed. On 7/10/18 at 11:48 PM, two surveyors entered Resident #41's room. Both surveyors noticed the fish like odor upon entering the room and noticed it was more pronounced near Resident #41's bed. On 7/10/18 at 11:51 AM, CNA #11 said due to two nose injuries she could not recognize the smell in Resident #41's room. On 7/10/18 at 11:51 AM, RN #2 said Resident #41 needed to be groomed. RN #2 said the CNAs gave baths to the residents and she did not know why Resident #41 did not receive her baths as scheduled. 2. Resident #44 was admitted to the facility on 6/1/18 with multiple diagnoses, including hypertension and a urinary tract infection. The admission MDS assessment, dated 6/8/18, documented Resident #44 was moderately cognitively impaired and required total assistance from one person for personal hygiene, including	F 677	Re-education was provided by the Chief Nursing Officer to include but not limited to, bathing and oral care process and documentation. The system is amended to include department manager rounds review of oral and bathing hygiene. The shower schedule was adjusted to provide consist days for scheduling of resident showers even with staffing challenges. Monitor The Chief Nursing Officer and/or designee will audit 5 residents for consistent bathing and oral care weekly for 4 weeks, then 2 residents weekly for 8 weeks. New admissions will be included in the oral care and bathing audits. Starting the week of August 30, 2018, the review will be documented on the QAPI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The Clinical Resource RN (mentor/consultant) will validate quality with monthly review and trending for QAPI. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.	

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F 677	Continued From page 19 toothbrushing. The 14-day MDS assessment, dated 6/15/18, documented Resident #44 was cognitively intact and required limited assistance from one person for personal hygiene, including toothbrushing. On 7/9/18 at 2:52 PM, Resident #44 stated the facility had not provided a toothbrush or toothpaste, since she was admitted to the facility (6/1/18). Resident #44 stated she was able to brush her own teeth independently, if she had the supplies to do so. Resident #44's care plan, dated 7/7/18 documented, "[Resident #44] requires set up assistance with personal hygiene." Resident #44's June 2018 ADL Report for personal hygiene, including toothbrushing, documented 28 out of 59 opportunities she required assistance; 21 out of 59 opportunities she was independent; and 10 out of 59 opportunities were left blank. Resident #44's July 2018 ADL Report for personal hygiene, including toothbrushing, documented 6 out of 22 opportunities she required assistance; 13 out of 22 opportunities she was independent; and 3 out of 22 opportunities were left blank. On 7/11/18 at 11:47 AM, CNA #2 stated Resident #44 was independent with her ADL's including brushing her own teeth. CNA #2 asked Resident #44 where she stored her toothbrush and toothpaste and Resident #44 stated, "I don't have any and never have" and denied CNA #2	F 677		

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	135051		07/13/2018

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F 677	Continued From page 20 approval to look through her 3 drawer nightstand. CNA #2 brought a toothbrush and toothpaste to Resident #44 and Resident #44 allowed her to place them in her nightstand. CNA #2 was unable to find a toothbrush or toothpaste in Resident #44's 3 drawer night stand. On 7/11/18 at 1:41 PM, the DNS and the Clinical Resource Nurse stated the Admission Coordinator was the person that provided toiletries to newly admitted residents. On 7/11/18 at 1:46 PM, the Administrator stated the Admission Coordinator did not always provide toiletries to new residents. On 7/11/18 at 2:06 PM, the Admission Coordinator stated she made sure the new resident's room was ready and the CNA assigned to the hallway was responsible to provide the toiletries to the new resident. On 7/11/18 at 2:12 PM, CNA #10 stated when a new resident arrived her responsibilities were to check the new resident's vital signs and weight. CNA #10 stated the central supply person provided the toiletries to new residents. On 7/11/18 at 2:29 PM, the DNS stated the central supply person only worked two days a week and was not available for interview. The DNS and the Clinical Resource Nurse, also present, stated they needed to work on a better system to communicate responsibilities for new residents. The DNS was unaware the CNAs were documenting Resident #44 required assistance with personal hygiene and Resident #44 did not have a toothbrush or toothpaste until CNA #2	F 677		

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F 677	Continued From page 21 provided them on 7/11/18. 3. Resident #27 was admitted to the facility on 11/22/16 with multiple diagnoses, including end stage renal disease, and diabetes mellitus with neuropathy. A quarterly MDS assessment, dated 5/16/18, documented Resident #27 was cognitively intact and required extensive assistance from two people for bathing. On 7/10/18 at 2:04 PM, Resident #27 stated she was provided a shower once a week and would like to have a shower two times a week. Resident #27's care plan, revised on 9/1/17, documented, "one staff assist with showers." The care plan did not include the days Resident #27 was scheduled to receive showers. The June and July 2018 ADL Reports documented Resident #27 was scheduled for showers on Tuesdays and Thursdays. The ADL Report documented Resident #27 received a shower on the following days: * 6/5/18 * 6/7/18 resident refused * 6/12/18 * 6/14/18 was left blank * 6/19/18 * 6/21/18 resident refused * 6/26/18 * 6/28/18 was left blank * 7/3/18 * 7/5/18 resident refused	F 677		

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F 677	Continued From page 22 * 7/10/18 On 7/12/18 at 5:03 PM, the DNS and Clinical Resource Nurse stated Resident #27 should have had showers twice a week and the care plan should be more specific on what days Resident #27 was scheduled for showers. The DNS stated when a resident refused a shower, the staff should offer one the next day. The DNS was unable to provide documentation Resident #27 was offered a shower the day following her refusals. 4. Resident #24 was readmitted to the facility on 9/27/17, with diagnoses which included Parkinson's disease, contracture to her left knee, left hip, right hip, right knee, and multiple sclerosis. A quarterly MDS assessment, dated 5/11/18, documented Resident #24 had a moderate cognitive impairment. The MDS assessment documented she was totally dependent on 1 to 2 staff members for all cares. The care plan area addressing Resident #24's ADL care, revised 3/22/16, documented Resident #24 required 1 staff member's assistance with bathing and did not specify how many staff members she required for personal hygiene. On 7/9/18 at 2:44 PM through 4:16 PM, Resident #24 was observed with stringy like greasy hair. a. The 5/1/18 through 7/11/18 ADL Report documented Resident #24 was to be provided oral care twice daily. The ADL documentation showed staff did not provide assistance with oral	F 677		

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F 677	Continued From page 23 care 36 out of 143 opportunities. b. The 5/1/18 through 7/11/18 ADL Report documented Resident #24 was to be provided showers Wednesdays and Saturdays. The ADL documentation showed Resident #24 received a shower on 5/16/18 and was not provided a shower on 5/19/18. Resident #24's next shower was on 5/23/18, 6 days later. Resident #24 was not provided a shower on 5/26/18 and her next shower was provided on 5/30/18, 6 days later. Resident #24 received a shower on 6/2/18 and refused a shower on 6/6/18, was not provided a shower on 6/9/18, and received her next shower on 6/13/18, 10 days later. Resident #24 was not provided a shower on 6/16/18 and 6/20/18 and her next shower was on 6/22/18, 9 days later. Resident #24 received a shower on 6/29/18, refused a shower on 7/30/18, did not receive a shower on 7/4/18, and her next shower was on 7/7/18, 8 days later. Additionally, there was no documentation Resident #24 was reapproached or offered a shower the next day when she refused showers. On 7/12/18 at 10:28 AM, the DNS state the oral care and the showers should be completed as scheduled. 5. Resident #17 was admitted to the facility on 4/4/08, with diagnoses which included muscle weakness and osteoarthritis. A quarterly MDS assessment, dated 5/1/18, documented Resident #17 had a moderate cognitive impairment. The MDS assessment documented he was totally dependent on 2 staff members for all cares except eating and for	F 677		

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F 677	Continued From page 24 personal hygiene he was dependent on assistance from 1 person. The MDS assessment documented he had a bilateral range of motion impairment to his upper and lower extremities. The care plan area addressing Resident #17's ADL care, revised 4/4/08, documented Resident #17 required the assistance of 1 staff member for bed mobility, bathing, personal hygiene, and dressing. The 5/1/18 through 7/11/18 the ADL Record documented Resident #17 was to be provided oral care twice daily. The ADL Record documented staff did not provide assistance with oral care 35 out of 143 opportunities. On 7/11/18 at 5:00 PM, the DNS stated oral care should be completed twice daily. 6. Resident #20 was readmitted to the facility on 12/27/15, with diagnoses which included dementia without behavioral disturbances. A quarterly MDS assessment, dated 5/7/18, documented Resident #20 had a severe cognitive impairment. The MDS assessment documented she was totally dependent or required extensive assistance of 1 to 2 staff members for all cares except eating. The care plan area addressing Resident #20's ADL care, revised 11/12/12, documented Resident #20 required 1 staff member's assistance with personal hygiene and dressing. The 5/1/18 through 7/11/18 ADL Report documented Resident #20 was to be provided	F 677		

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F 677	Continued From page 25 oral care twice daily. The ADL Report documented staff did not provide Resident #20 assistance with oral care 32 out of 143 opportunities. On 7/11/18 at 5:00 PM, the DNS stated oral care should be completed twice daily. 7. Resident #159 was readmitted to the facility on 7/24/16, with diagnoses which included difficulty walking and abnormalities in gait and mobility. A quarterly MDS assessment, dated 12/23/17, documented Resident #159 had a moderate cognitive impairment. The MDS assessment documented he required physical help of one staff member with bathing. The care plan area addressing Resident #159's ADL care, revised 8/18/17, documented Resident #159 required 1 staff member's assistance with bathing and his bath days were on Tuesdays and Thursdays. The 1/1/18 through 2/12/18 ADL Report documented Resident #159 was to be provided showers Tuesdays and Thursdays. The ADL documentation showed Resident #159 received a shower on 1/16/18 and he refused a shower on 1/18/18 and his next shower was on 1/23/18, 6 days later. Resident #159 received a shower on 2/1/18 and did not receive showers on 2/6/18 and 2/8/18, and was discharged from the facility on 2/11/18, 10 days later. Additionally, there was no documentation Resident #159 was reapproached or offered a shower the following day if he refused.	F 677		

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F 677	Continued From page 26 On 7/13/18 at 11:12 AM, the DNS stated the facility had a shower schedule by room numbers that determined the days residents received showers. The DNS stated residents with the Tuesday and Thursday scheduled would go 5 days between showers and if showers were missed then potentially longer. The DNS stated residents should receive showers on shower days and if residents missed their shower days then staff should offer showers the next day. The DNS stated CNAs knew which showers needed completed by the residents' names populating into the computer system. The DNS stated if a resident's shower was not completed there was not an alert in the system to notify staff that showers were not completed.	F 677		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure there was an ongoing activity program to meet individual resident needs. This was true for 1 of 16 residents (#17) sampled for quality of life concerns and created the potential for residents	F 679	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Canyon West of Cascadia does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility	8/30/18

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F 679	Continued From page 27 to become bored or depressed when not provided with meaningfully engagement throughout the day. Findings include: Resident #17 was admitted to the facility on 4/4/08, with diagnoses which included muscle weakness and osteoarthritis. A quarterly MDS assessment, dated 5/1/18, documented Resident #17 had a moderate cognitive impairment. The MDS assessment documented he was totally dependent on 2 staff members for all cares except eating and for personal hygiene he was dependent on assistance from 1 person. The care plan area addressing Resident #17's Activities, revised 11/15/17, documented Resident #17 had little or no activity involvement and staff provided one to one visits 2-3 times a week. The 5/1/18 through 7/11/18 ADL Record documented Resident #17 was to be provided one to one activities visits 2-3 times a week. The ADL documentation showed staff provided one to one visits 6 out of 31 opportunities. On 7/9/18 from 2:31 PM through 3:48 PM, Resident #17 was observed in bed. On 7/10/18 at 9:05 AM, Resident #17 was observed in his room sitting next to his bedside. The television was not on and he was staring out the window. Resident #17 was observed again on the same day from 6:14 PM through 7:19 PM in the same position.	F 679	admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. Resident Specific The ID team reviewed resident #17 for an ongoing activity program. The plan of care is updated to address documentation of individual needs and plan implementation. Other Residents The ID team reviewed other residents with cognitive impairment for an ongoing activity program that meets individual resident needs. Adjustments have been made as indicated. Facility Systems The Activity Director and activity staff is educated to validate ongoing activity programs are in place to address residents with cognitive impairment needs. Re-education was provided by the Chief Nursing Officer to include but not limited to, review of ongoing activity programs are in place to address needs of cognitively impaired residents, and documentation is established for tracking of plan implementation. The system is amended to include systematic review of the activity program to address various types of residents and their interests, to include cognitively impaired residents.	

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F 679	Continued From page 28 On 7/10/18 from 1:24 PM through 1:55 PM, Resident #17 was observed sitting in the hallway leaning over the right side of his wheelchair. On 7/11/18 at 9:21 AM, 9:53 AM, and 2:30 PM, Resident #17 was observed in bed with the television on and his eyes closed. On 7/12/18 at 2:42 PM, the Activities Director stated Resident #17 stayed in his room most days. The Activities Director stated he attended church services on Sundays and liked back rubs and massages. The Activities Director stated the activities personnel were to provide one to one visits with Resident #17 two to three times per week. The Activities Director stated the documentation did not show what was being completed with Resident #17.	F 679	Monitor The Chief Executive Officer (licensed administrator) and/or designee will audit 5 activity plans for implementation with¬¬¬¬ cognitively impaired residents to validate an ongoing activity program to meet individual needs is in place weekly for 4 weeks, then 2 residents weekly for 8 weeks. Starting the week of August 30, 2018, the review will be documented on the QAPI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.	
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, policy review, and record review, it was determined the facility failed to ensure professional standards of practice were followed for 3 of 18 sampled residents (#20, #30, and #41) reviewed for standards of practice. Resident #20	F 684	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Canyon West of Cascadia does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility	8/30/18

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F 684	Continued From page 29 was harmed when she developed new wounds without consistent weekly wound assessments, measurements, treatments, and consistent care plan revisions. Resident #30 had the potential for harm when neurological assessments were incomplete after an unwitnessed fall. Resident #41 had the potential for harm when he received a nebulizer treatment without supervision. These failed practices had the potential to adversely affect or harm residents whose care and services were not delivered according to accepted standards of clinical practices. Findings include: 1. Resident #20 was readmitted to the facility on 12/27/15, with diagnoses which included dementia without behavioral disturbances. A quarterly MDS assessment, dated 5/7/18, documented Resident #20 had a severe cognitive impairment. The MDS assessment documented she was totally dependent or required extensive assistance of 1 to 2 staff members with all cares except eating. The MDS assessment documented Resident #20 had skin tears. A previous quarterly MDS assessment, dated 2/4/18, documented she did not have skin tears or wounds. The care plan area addressing Resident #20's skin impairments, initiated 5/9/18, documented Resident #20 experienced skin impairments such as complications related to areas of injury to her left lower extremity abrasion, initiated 7/9/18. The care plan documented staff were to monitor and document the location, size, and treatment of skin injury and report abnormalities, failure to heal, any signs and symptoms of infections, and/or maceration to the physician.	F 684	admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. Resident Specific The clinical management team reviewed the following: • Resident #20 has a current wound assessment and documentation monitors, an updated plan to manage pain including prior to wound treatment, resolution and prevention plan for cellulitis, treatment plan update with use of tubi-grips, and re-evaluation of the resident scratching/ picking at her legs. • Resident #30 had incomplete neurological checks documented in April of 2018, no change in neurologic status. No additional documentation required. • Resident #41 has been assessed for self-med with nebulizer mask and/or supervision by the nurse. Plan is established, and orders received. Other Residents The clinical management team reviewed other residents with current wounds for complete plans and management of pain, resident falls with incomplete neurochecks since July for potential negative outcomes were reviewed, and residents who receive nebulizer treatments for implementation of self-medication program were assessed.	

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F 684	Continued From page 30 The care plan area addressing Resident #20's wound infection to the left lower leg, initiated 7/9/18, documented Resident #20 experienced signs and symptoms of wound infection. The care plan documented staff were to monitor and record the amount, color, and odor of wound drainage and provide treatments per physician orders. The Braden Scale, dated 5/6/18, documented Resident #20 was at risk for developing pressure ulcers. a. Weekly Skin Monitoring of the wound on the back of Resident #20's left lower leg was to be completed weekly until the skin impairment resolved. The monitoring was to assess the healing progression of the wound. Resident #20's Weekly Skin Alternation Reports documented she developed multiple wounds which were not sufficiently monitored and the documentation was not consistent, as follows: * A Weekly Skin Alteration Report, dated 2/3/18, documented Resident #20 had a 6 cm triangular shaped skin tear on the front of her right lower leg, first observed 1/26/18. * A Weekly Skin Alteration Report, dated 4/30/18, documented Resident #20 had a 10 cm 1/2 moon shaped skin tear on the back of her left lower leg, first observed 4/30/18. * A Weekly Skin Alteration Report, dated 5/9/18, documented Resident #20 had an 8 cm by 3 cm skin tear on the back of her left lower leg, first observed 4/30/18. The report documented	F 684	Adjustments have been made as indicated. Facility Systems Licensed nurses are educated to provide care according to appropriate standards of practice. Re-education was provided by the Chief Nursing Officer to include but not limited to, include weekly wound assessments, measurements, treatments, consistent care plan revisions for new wounds, timely transcription of physician orders, treatment documentation when completed, continue with wound expert treatment as physician directed, plans to prevent wound infection, and pain management prior to/during/and in conjunction with ongoing wound management; complete timely and thorough neurological assessments after unwitnessed falls and falls where a resident was observed to strike their head, and provide appropriate supervision during nebulizer treatments and/or assessment for self-medication as indicated. The system is amended to include external/onsite review of significant wounds, weekly wound rounds with facility staff, validation of wound order transcription and documentation, and review of pain management program for residents with wounds. Neurological check system established to validate consistent implementation with unwitnessed falls during shift change and clinical meeting. New orders for nebulizers are reviewed in clinical meeting for nurse supervision or self-med	

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F 684	Continued From page 31 Resident #20's pain settled down as soon as her dressing change was completed. The report documented the half-moon shaped skin tear to the left lower leg was dark red with bruising. * A Weekly Skin Alteration Report, dated 5/16/18, documented Resident #20 had a 7.5 cm by 3 cm skin tear on the back of her left lower leg, first observed 4/30/18. The report documented Resident #20's pain settled down as soon as her dressing change was completed. The report documented the skin tear was improving with less redness and bruising. * A Weekly Skin Alteration Report, dated 5/23/18, documented Resident #20 had a 7 cm by 5 cm skin tear on the back of her left lower leg, first observed 4/30/18. The report documented Resident #20's pain resolved once the treatment was completed. The report documented the skin tear was healing slowly. The report documented the covering skin appeared to have sloughed off (shedding of dead tissue from surrounding living tissue) leaving healthy tissue. * A Weekly Skin Alteration Report, dated 5/30/18, documented Resident #20 had a 6.8 cm by 5 cm skin tear on the front of her left lower leg, first observed 4/30/18. The report documented Resident #20 only complained of pain during dressing changes. The report documented the skin tear was healing slowly. The report documented Resident #20 was on antibiotics for cellulitis and the redness had decreased. * A Weekly Skin Alteration Report, dated 6/6/18, documented Resident #20 had a 5.8 cm skin tear of red granulation tissue with white slough	F 684	assessment as indicated. Monitor The Chief Nursing Officer and/or designee will audit 5 resident records/residents for standards of practice weekly related to wound care, pain management, neurological checks post fall, and nebulizer supervision/self-medication for 4 weeks, then 3 residents weekly for 8 weeks. Starting the week of August 30, 2018, the review will be documented on the QAPI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The Clinical Resource RN (mentor/consultant) will validate quality with monthly review and trending for QAPI. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.	

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F 684	Continued From page 32 throughout on the back of her right lower leg, first observed 4/30/18. The report documented Resident #20's pain resolved with the completion of the dressing changes. The report documented the wound was showing signs of improvement and staff were to continue with Santyl per physician's orders. * A Weekly Skin Alteration Report, dated 6/13/18, documented Resident #20 had a 6 cm by 2.5 cm skin tear on the back of her left lower leg, first observed 4/30/18. The report documented Resident #20's pain resolved with the completion of the dressing changes. The report documented the wound was healing slowly and to continue with physician's orders. The monitoring was not completed for the weeks of 6/18/18 and 6/25/18. A Weekly Skin Alteration Report, dated 7/6/18, documented Resident #20 had three wounds on her left lower leg, first observed on 4/40/18. She had one wound on the anterior (front) of her left lower leg 5 cm by 3.5 cm, a 4 cm by 2.5 cm wound on the posterior (back) of her left lower leg, and a 0.7 cm by 0.7 cm wound on her lateral (side) left lower leg. The report documented slough (dead tissue, usually cream or yellow in color) was present on the anterior and posterior wounds with odor, purulent (pus) discharge, signs and symptoms of infection, and the wound progression had deteriorated. b. Resident #20's 5/1/18 through 7/11/18 TAR documented treatments were administered. Resident #20 was missing the following treatments:	F 684		

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F 684	Continued From page 33 * Staff was to cover steri strips to the left leg with biatain or mepilex lite every 3 days until resolved for a skin tear, ordered 5/14/18 and discontinued 6/4/18. The treatment was not completed on 5/14/18, 5/23/18, and 6/4/18. *Staff was to clean wound on the side of Resident #20's left leg with wound cleanser and apply Santyl to the wound bed and cover with foam dressing every other day, ordered 6/7/18 until 6/11/18. The treatment was not completed on 6/8/18. * Staff was to complete the wound care order of silvasorb gel to wound bed with an island dressing every 2 days, ordered 6/12/18 and discontinued 7/6/18. The treatment was not completed on 6/16/18, 6/20/18, and 6/22/18. c. Resident #20 developed an infection in her wounds: * A Patient Infection Report, dated 6/1/18, documented Resident #20 developed cellulitis (potentially serious bacterial skin infection) with heat, redness, swelling, serous (clear, thin, watery) drainage at the site, and was on antibiotic therapy. * A Patient Infection Report, dated 7/6/18, documented Resident #20 developed cellulitis with heat, redness, swelling, presence of pus at the wound site, and was on antibiotic therapy related to wound infection of the lower leg and signs and symptoms of infections. d. Resident #20's Tubigrips (elastic tubular	F 684		

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F 684	Continued From page 34 compression bandage) were observed bunched up on her legs as follows: * On 7/10/18 at 2:17 PM, Resident #20 was observed in bed with Tubigrips on both legs. The Tubigrips were rolled down and bunched on her right leg leaving an indentation where the bunching was localized. CNA #7 and CNA #6 were present and did not notice the bunched Tubigrips and did not correct the stockings. * On 7/10/18 at 6:36 PM, Resident #20 was observed sitting in her wheelchair in the hallway. Resident #20 had her pants hiked up her legs to her knee and her left leg was red and irritated looking. Resident #20's right leg looked purple in color and the Tubigrip remained bunched up and the front of her right leg was scratched. * On 7/10/18 at 6:43 PM, LPN #4 assessed Resident #20's right and left leg. Resident #20's Tubigrip on her right leg was bunched up and the front of her leg was scratched and bleeding. LPN #4 stated she needed to remove Resident #20's Tubigrip on her right leg because it was bunched up and the Tubigrip caused an indentation into her leg. LPN #4 stated the nursing staff were responsible for placing and removing the Tubigrips on Resident #20. LPN #4 stated nursing staff monitored Resident #20's Tubigrips for functionality and the CNAs should report to nursing if the stockings were bunched and correct the stockings to prevent pressure points. * On 7/11/18 at 9:14 AM, the DNS and the Clinical Resource Nurse stated they did not know if the Weekly Skin Alteration Reports were documenting the same wounds. The DNS stated	F 684		

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F 684	Continued From page 35 a nurse had spoken with her about Resident #20's Tubigrips bunching up. The DNS stated she did not know the Tubigrip was bunched up from 2:00 PM till 6:00 PM and the surveyor had notified the LPN about the bunching. * On 7/11/18 at 10:47 AM, Resident #20 was observed in bed with her Tubigrips bunched on her right leg leaving an indentation where the bunching was localized. The Clinical Resource RN corrected the bunched Tubigrips. * On 7/11/18 at 1:30 PM, LPN #1 stated Resident #20 did not have all three wounds on her left leg from the beginning. LPN #1 stated the wound on the back of her leg was from the tape of the bandages. * On 7/11/18 at 1:54 PM, Resident #20 was observed being assisted into bed by CNA #2 and CNA #4 with a Hoyer lift and the Tubigrip on her right leg was bunched up. CNA #2 and CNA #4 assisted Resident #20 into bed for a nap and change her soiled briefs. While CNA #2 and CNA #4 assisted her with cares and rolled her from side-to-side she moaned out and continued to moan out throughout the process. The two CNAs were changing her attends and CNA #2 changed her gloves after performing pericare, and did not perform hand hygiene between glove changes. CNA #4 removed her gloves after completing pericare, removed the soiled trash bag, replaced the liner, and left with room without performing hand hygiene. On 7/11/18 at 1:54 PM Resident #20's roommate stated Resident #20 was in pain often at night and when staff interacted with her during cares.	F 684		

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F 684	Continued From page 36 Resident #20's roommate stated Resident #20 scratched herself because she was in pain. On 7/11/18 at 1:59 PM, CNA #2 stated she should have performed hand hygiene between glove changes but forgot. On 7/11/18 at 2:06 PM, LPN #1 stated Resident #20's Tubigrip on her right leg was bunched up and an indentation was present on the right and left leg. LPN #1 began the process of the dressing change of the two bandages on Resident #20's left leg. LPN #1 asked CNA #7 to assist her with the dressing change by holding Resident #20's leg in place. LPN #1 removed Resident #20's Tubigrips from her left leg and removed the soiled bandages. While Resident #20's bandages were removed she grimaced in pain and cried, "Owww." LPN #1 began cleansing the wounds with cleanser and removed her gloves once she completed the process. LPN #1 did not perform hand hygiene before placing new gloves on her hands. While Resident #20's wound was being cleansed she was crying out, "Quit it." "Get your dam." Resident #20 was pulling her leg back and trying to get her leg out of CNA #7 hands. LPN #1 removed a tube of Santyl from her pocket and opened the tube and applied and spread the ointment to the wound base using the end of the tube. While LPN #1 spread the ointment on Resident #20's wounds base she continued to cry and pull her leg back. Resident #20 was covering her face with her blanket and crying. LPN #1 asked Resident #20 if the dressing change was that bad and Resident #20 shook her head yes. On 7/11/18 at 2:20 PM, LPN #1 stated Resident	F 684		

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F 684	Continued From page 37 #20 did not receive routine pain medications and this dressing change was the worst interaction she had seen Resident #20 experience. LPN #1 stated she had not offered PRN pain medications prior to the dressing change and she would next time. LPN #1 stated she should have washed her hands between moving from dirty to clean in the dressing change process. On 7/11/18 at 2:37 PM, LPN #5 adjusted Resident #20's Tubigrips and Resident #20 cringed while her leg was being touched. Resident #20's clinical records did not contain orders or care plan directions for her Tubigrips for nursing staff of when to remove and apply the Tubigrips and check the skin under the stocking. On 7/11/18 at 5:00 PM, the DNS stated the facility was aware of concerns with wound management and had a contract agency set up to manage wounds. The DNS stated the measurements on the wounds should be completed weekly and she could not find the measurements for the missing dates. The DNS stated the treatments should be completed per physician's orders. The Clinical Resource Nurse, also present, stated Resident #20's leg got infected because she picked at the wound and removed the bandages. Resident #20's clinical records did not contain documentation she removed her bandages or picked at her wounds. The DNS stated during wound care nurses should perform hand hygiene, apply gloves, remove soiled bandages and cleanse the wounds, perform hand hygiene and apply fresh glove. The DNS stated the nurse should use a Q-tip to apply the ointment onto the wound base	F 684		

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F 684	Continued From page 38 and apply new bandages onto the wounds. The DNS stated the nurses should wash their hands after the process was completed. 2. Resident #41 was admitted to the facility on 6/4/18, with multiple diagnoses which included cerebrovascular accident (stroke). Resident #41's quarterly MDS assessment, dated 5/7/18, documented her cognition was moderately impaired and she required extensive assistance from two staff members for most ADLs. On 7/9/18 at 2:34 PM, Resident #41 was observed in bed, eyes closed, head of bed elevated about 45 degrees, and with a face mask on (aerosol mask) attached to a nebulizer cup which was connected to a tube to the nebulizer machine. The nebulizer cup was observed to be empty, no mist was coming out, and the nebulizer machine was on. The strap of the face mask on the left side was observed touching Resident #41's left eye. On 7/9/18 at 2:40 PM, LPN #6 said she administered the nebulization treatment to Resident #41 about 10 minutes earlier. The LPN said she did not stay with Resident #41 while she was on nebulization treatment because she knew Resident #41 would not remove the face mask. If she knew a resident would remove the face mask she would then frequently check on the resident to make sure the face mask was still on their face. On 7/9/18 at 2:54 PM, RN #2 said the nurse should stay with the resident during nebulization	F 684		

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F 684	Continued From page 39 until the treatment was completed unless there was a self-administration order and assessment completed. 3. Resident #30 was admitted to the facility on 7/2/18 with diagnoses which included left sided hip fracture, stroke, and traumatic intercranial hemorrhage (brain bleed). An admission assessment dated 3/15/18, documented Resident #30 was severely cognitively impaired, had a history of intercranial hemorrhage, and required extensive assistance with all activities of daily living. A history and physical dated 3/9/18, documented Resident #30 was admitted to the hospital for an intercranial hemorrhage following a fall, prior to admission to the facility. The facility's Fall Response and Management policy, dated 11/28/17, documented, an unwitnessed fall would require the following actions: * Evaluate the resident for injury. * Monitor neurological assessments per physician's orders or monitor every 15 minutes for 1 hour, then every 30 minutes for 1 hour, then every hour for 2 hours or until condition stabilizes, if resident has hit his or her head. * Follow-Up and Monitoring - Evaluate the residents condition for at least 72 hours post fall. A Post Fall Investigation Report dated 4/13/18, documented Resident #30 had an unwitnessed	F 684		

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F 684	Continued From page 40 fall from his Geri chair. He was found on the floor, on his left side. He denied pain. A Neurological Record initiated 4/13/18, documented Resident #30's vital signs were not documented on 4/13/18 at 9:45 PM, 10:15 PM, or 10:45 PM. On 4/14/18 at 5:15 AM, a neurological assessment was not completed. On 4/15/18 at 9:15 AM, a neurological assessment was not documented. On 4/15/18 at 1:15 PM and 5:15 PM, no vital signs or neurological assessments were documented. On 7/11/18 at 3:10 PM, the DNS stated she was aware there were problems with neurological checks being completed for falls. She stated she expected her staff to know when neurological checks were required and how to complete them.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review it was	F 686	This Plan of Correction is prepared and	8/30/18

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F 686	Continued From page 41 determined the facility failed to ensure residents consistently received necessary treatment to promote healing of pressure ulcers and prevent infection from developing. This was true for 1 of 8 residents (#1) reviewed for pressure ulcers. This deficient practice caused harm to Resident #1 when he developed an infection to his pressure ulcer, required debridement, and use of antibiotics. Findings include: Resident #1 was admitted to the facility on 12/9/17 and readmitted on 1/3/18 with multiple diagnoses, including muscle weakness and unstageable pressure ulcer. A Hospital Admitting report, dated 12/25/17, documented Resident #1 was sent to the hospital due to fever and was discovered to have sepsis (blood infection) due to urinary tract infection. The physical examination documented "mildly erythematous (abnormal redness) 1 centimeter (cm) irritated area on the left. Lateral foot metatarsal area has a boggy ecchymotic (blood underneath the skin greater than 1 cm) area on the left heel. Right heel appears relatively unremarkable..." An Initial Nursing Evaluation, dated 1/3/18, completed upon Resident #1's return from the hospital, documented a 4 x (by) 4 cm SDTI to the left heel, and it was black in color. Resident #1's Braden Scale for Predicting Pressure Sore Risk, dated 1/3/18, documented he was at moderate risk for developing pressure ulcers. Resident #1's Care Plan, initiated on 1/15/18,	F 686	submitted as required by law. By submitting this Plan of Correction, Canyon West of Cascadia does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. Resident Specific Resident #1 has discharged. Other Residents The clinical management team reviewed other residents for necessary treatment to promote healing of pressure ulcers and prevent infection from developing. Adjustments have been made as indicated. Facility Systems Licensed nurses are educated to the prevention and treatment of pressure ulcers. Re-education was provided by the Chief Nursing Officer to include but not limited to, include weekly wound assessments, measurements, treatments, consistent care plan revisions for new wounds, timely transcription of physician orders, treatment documentation when completed, continue with wound expert treatment as physician directed, plans to prevent infection, and pain management prior to/during/and in conjunction with	

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F 686	Continued From page 42 documented he had an SDTI to his left heel. Interventions were: staff to apply Prevalon (pressure relief) boots at all times as resident allows, use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface, encourage good nutrition and hydration to promote healthier skin, keep skin clean and dry, use lotion on dry skin and wound as ordered. Resident #1's quarterly MDS assessment, dated 3/22/18, documented he was moderately cognitively impaired and required extensive assistance of two staff members for all cares except for eating and personal hygiene. The MDS assessment documented Resident #1 had one unstageable pressure ulcer with SDTI and had no infection. Resident #1's quarterly MDS assessment, dated 6/22/18, documented he had one unstageable pressure ulcer and an infection of the foot. Resident #1's Weekly Pressure Ulcer Report (WPUR), Nursing Notes (NN), Physician Notes, Wound Clinic Notes (WCN), and Laboratory Results documented a pressure ulcer on his left heel as follows: * 1/3/18 WPUR - 4 x 4 cm, stage - SDTI, noted upon admission, black in color, firm, redness surrounding wound, blanches around wound, non blanchable to 4 x 4 SDTI. Prevalon boots on at all times. * 1/23/18 NN - wound RN (registered nurse) stated no changes to Resident #1's left heel, remains black in color, will continue to follow	F 686	ongoing wound. The system is amended to include external/onsite review of significant wounds, weekly wound rounds with facility staff, validation of wound order transcription and documentation, and review of pain management program for residents with wounds. Monitor The Chief Nursing Officer and/or designee will audit all residents with pressure ulcers for validation they receive necessary treatment to promote healing of pressure ulcers and prevent infection from developing, weekly for 4 weeks, then 2 residents weekly for 8 weeks as applicable. Starting the week of August 30, 2018, the review will be documented on the QAPI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The Clinical Resource RN (mentor and consultant) will validate quality with monthly review and trending for QAPI. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.	

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F 686	Continued From page 43 weekly. * 1/30/18 NN - wound RN stated no changes to Resident's #1 left heel, remains black in color. * January 2018's TAR - documented Prevalon boots were on at all times, * 2/6/18 Nursing Practitioner's Notes - documented Resident #1 was referred to the wound clinic for evaluation and treatment of his left heel wound. * 2/8/18, WCN - 3.71 x 3.54 x 0 cm pressure ulcer not healed, orders included to apply Iodosorb gel to wound bed or paint with Betadine and cover with foam. Refer to vascular for evaluation and treatment, offloading at all times, avoid prolonged standing in one place and return in one week. * 2/12/18, NN - Resident #1 went to the wound clinic on 2/8/12, order to apply Iodosorb gel topically to left heel then cover with Mepilex or foam dressing, refer to vascular for evaluation and treatment. * 2/16/18 WCN - 4 x 4.8 cm, orders included Betadine to wound bed, change dressings 2-3 times per week, cover wound with appropriate dressing to manage exudate (drainage) and secure dressing in place, offloading at all times and return in one week. * 2/16/18 Physician's Notes - "The appearance of the ulcer and the lack of significant arterial insufficiency suggest that this is a pressure ulcer...we will evaluate further with arterial duplex	F 686		

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F 686	Continued From page 44 study. Patient will return for follow-up in 4 weeks." * 2/16/18 NN - dressing to left heel changed, * 2/23/18 NN - heel not as moist, more dry, * 2/27/18 at 2:38 PM, NN - left heel SDTI with no significant change noted, * 2/26/18 WPUR - 4 x 4 cm, stage - SDTI, Iodosorb Gel 0.9% daily as ordered by the wound clinic, float heels and apply boots continuously. * 2/27/18 at 7:15 PM, NN - resident refused to go to speech therapy due to pain left hand and wound on left heel. * February 2018 TAR - documented Resident #1's left heel was offloaded, and was treated with Iodosorb Gel 0.9% and covered with Mepilex dressing from 2/13/18 to 2/27/18. * 3/1/18 WCN - 3.8 x 4.5 x 0 cm, scant serous (thin, watery) exudates, 76% - 100% eschar, Betadine to wound bed, cover with ABD dressing (highly absorbent dressing that provides padding and protection for wounds), no foam, and wrap with gauze, change dressings daily, offloading boots at all times, return appointment in 3 weeks. There was no documentation found on Resident #1's clinical record that he was sent back to the Wound clinic after the three week period. * 3/2/18 at 2:39 PM, NN - new order obtained to left heel, cleanse left heel with wound cleanser pat dry and paint wound bed to left heel with	F 686		

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F 686	Continued From page 45 Betadine, cover with ABD, no foam and wrap with gauze change daily, continue to offload, boots at all times. * 3/5/18 WPUR - new orders received from wound clinic: Cleanse left heel daily with wound cleanser, pat dry, apply betadine to wound bed, cover with ABD pad (no foam) and wrap with gauze. * 3/6/18 at 2:35 PM, NN - pressure wound to left heel continues to be black in color, hard, 75-100 %eschar. On 3/11/18 to 3/15/18, Resident #1 was admitted to the hospital due to hyperkalemia (high potassium in the blood). * 3/15/18 NN - resident was readmitted to the facility, 5 x 6 cm, unstageable pressure ulcer * 3/15/18 WPUR - 5 x 6, SDTI, black and hard, unstageable pressure ulcer to left heel 2 cm larger upon readmission from the hospital. * 3/22/10 WPUR - 5 x 6 cm, SDTI, Prevalon boots, and float heels along with repositioning. * 3/22/18 Physician Notes - treatment options were discussed with the family to improve healing of the pressure ulcer, and that the primary cause of the ulcer was pressure due to Resident's #1's limited mobility, and occlusion of the posterior tibial artery was a factor in the delayed healing. It was in the opinion of the family Resident #1 would not want aggressive procedures.	F 686		

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F 686	Continued From page 46 * 3/27/18 NN - "Family conference held recently w[ith] wishes for comfort care and no further hospitalizations..." * March 2018 TAR - documented Resident #1's left leg was offloaded using Prevalon boots from 3/1/18 to 3/10/18 and staff were to clean the left heel with wound cleanser, apply Betadine swab and cover wound with primary dressing using ABD pad, and then apply secondary dressing using Kerlix. This order was discontinued on 3/10/18 when Resident #1 was sent to the hospital, and was readmitted to the facility again on 3/15/18. There was no documentation Resident #1 received treatment on his left heel from 3/16/18 through 3/19/18. * 4/2/18 WPUR - 5/6 cm, unstageable, float heels and repositioned resident, * 4/9/18 WPUR - no measurement, covered with 100% eschar (dark, crusty or leathery dead tissue), Prevalon boots and floating heels for pressure relief. Foam dressing covering wound for added protection. No signs and symptoms of infection. Per the wound clinic order dated 3/1/18 no foam was to be used to cover the wound. * 4/16/18 WPUR - 3.8 x 3 cm, unstageable, covered with hard black eschar, no change on treatment. * 4/23/18 WPUR - 3.8 x 3 cm, unstageable, no change on treatment. Complained of pain with dressing,	F 686		

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F 686	Continued From page 47 * 4/30/18 WPUR - 3.8 x 3 cm, unstageable, had some pain with dressing, 100% eschar, * April 2018 TAR - did not include documentation Resident #1's left heel wound treatment was completed on 4/2/18, 4/12/18 and 4/13/18. The TAR did not include documentation Prevalon boots were applied to the resident. * 5/7/18 WPUR - 3.8 x 3 cm, unstageable, with black hard eschar, complained of pain during treatment. * 5/14/18 WPUR - 3.8 x 3 cm, unstageable with hard black eschar * 5/21/18 WPUR - 3.8 x 3 cm, unstageable with hard black eschar, denied pain during treatment * 5/28/18 WPUR - 3.5 x 4.4 cm, unstageable, eschar is starting to lift at edges, faint odor noted during treatment. * May 2018 TAR - did not include documentation Resident #1's wound treatment was completed on 5/4/18, 5/10/18, 5/14/18, 5/15/18, 5/16/18 and 5/23/18. The TAR did not include Prevalon boots was applied to the resident. * 6/4/18 WPUR - 3.8 x 3.8 cm, unstageable, eschar is lifting slightly at the edges. * 6/11/18 Physician Notes - "...He has been followed by wound care clinic in the past but no recent evaluations are documented...Currently he is DNR (do not resuscitate) with comfort measures only. I discussed minimizing his scheduled medications to only those absolutely	F 686		

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F 686	Continued From page 48 necessary to providing him comfort but he states he would like to continue those as well as seek treatment for the pain in his heel. * 6/11/18 WPUR - no measurement, wound developed an increasing odor, will refer to the wound clinic. * 6/14/18 WCN - 3.6 x 4 x 0, small serous exudates with strong odor, eschar 76 - 100%, surgical abridgement done, wound treatment orders included: cleanse wound and peri-wound with Dakins solution, barrier ointment to protect surrounding skin, 1/4 Dakins moistened gauze to wound bed, cover with ABD/Kerlix, change dressing twice a day and as necessary, offloading at all times. * 6/15/18 Laboratory result - light growth of Coagulase Positive Staphylococcus (bacterial infection). * 6/19/18 Nutrition progress note - followed by the wound clinic, due to personal wishes Resident #1 would not be started on any further supplements/additional foods for healing/weight maintenance. * 6/20/18 WPUR - 3.6 x 4 cm, unstageable, eschar patch is smaller, less odor this week, wound was positive for Methicillin Resistant Staphylococcus Aureus (MRSA), Dakins wet to dry 2 x a day. * 6/21/18 WCN - 3.03 x 2.88 x 0.5 cm, small serous exudates with mild odor, 76-100% eschar, treatment the same.	F 686		

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F 686	Continued From page 49 * 6/27/18 WPUR - no measurement, no eschar present, skin blanches around wound, complained of pain when pressure is applied with or without Prevalon boots. * 6/28/18 WCN - 2.83 x 2.74 x 0.5 cm, small amount of exudate with mild odor, wound orders included cleanse wound with Dakins solution, barrier ointment to protect surrounding skin, 1/4 Dakins moistened gauze to wound bed, and cover with ABD pad and Kerlix, change dressings BID/PRN * June 2018 MAR - Resident #1 started on Doxycycline Hyclate Tablet 100 milligrams (mg) one tablet every 12 hours, and amoxicillin clavulanate 875-125 mg tablet twice a day for 2 weeks. * June 2018 TAR - Did not include documentation Resident #1's left heel wound treatment was completed on 6/8/18, 6/9/18, 6/10/18, 6/15/18, 6/16/18, 6/17/18. On 6/18/18 TAR documented the frequency of wound treatment was changed to twice a day. Resident #1's left heel dressing was done once a day instead of twice a day on 6/18/18, 6/19/18, and 6/23/18, and no wound treatment was documented on 6/27/18. The TAR did not include documentation Resident #1's left leg was offloaded. The 6/14/18 WCN orders documented Resident #1's dressing was to be changed twice a day and as needed. The order was included on the TAR on 6/18/18, 4 days later. * 7/4/18, WPUR - 6 x 6 x 1 cm, stage 3	F 686		

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F 686	Continued From page 50 * 7/8/18, WPUR - 6 x 6 x 1 cm, stage 3, wound bed with new onset of eschar noted. On 7/12/18 at 3:02 PM, RN #2 reviewed Resident #1's record and said the nurse could have completed the treatments and forgot to document them. The facility failed to consistently implement the wound dressing orders and follow the wound clinic order to bring Resident #1 back in 3 weeks after his appointment on 3/1/18. Resident #1 was seen again by the Wound Clinic on 6/14/18 when increasing odor was noted from his left heel. Resident #1 was harmed when the SDTI to his left heel deteriorated, became infected, required surgical debridement, and required the use of oral antibiotics.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a	F 688		8/30/18

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F 688	Continued From page 51 reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure residents received treatment and services for a restorative nursing program. This is true for 3 of 4 residents (#17, #22, and #24) reviewed for restorative nursing services. This failure created the potential for Resident #17, #22, and #24 to experience a decline in Range of Motion (ROM). Findings include: 1. Resident #22 was readmitted to the facility on 9/1/17 with multiple diagnoses, including a contracture to the left hand and dementia. A quarterly MDS assessment, dated 5/9/18, documented Resident #22 was severely cognitively impaired, required extensive assistance from two people, and had limited ROM impairments in both upper and lower extremities. Resident #22's July 2018 Physician's Medication Order Summary Report, on 4/16/17 documented, "RNA" (Restorative Nursing Assistant). Resident #22's care plan did not include a restorative nursing program. Resident #22's 7/1/18 - 7/11/18 ADL Record documented the RNA provided passive ROM to her bilateral upper and lower extremities 2 out of 22 opportunities; 1 out of 22 opportunities were documented "not applicable"; and 19 out of 22 opportunities were left blank.	F 688	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Canyon West of Cascadia does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. Resident Specific The clinical management team reviewed the following: • Resident #17 has been evaluated for a restorative nursing program after a decline in ADLs. The care plan and documentation monitors have been established as indicated. • Resident #22 restorative nursing program has been added to the care plan and established for implementation. • Resident #24 ROM and splint use with skin checks has been established. Other Residents The clinical management team reviewed other residents to validate an effective restorative nursing program is developed	

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F 688	Continued From page 52 On 7/12/18 at 9:12 AM, the DNS stated Resident #22 should have received 15 minutes of passive ROM to her bilateral upper and lower extremities and the blanks indicated the restorative therapy was not completed. The DNS stated Resident #22 did not receive treatment and services from the restorative nursing assistants because they were pulled to work the floor. On 7/12/18 at 9:39 AM, LPN #2 and CNA #3 stated Resident #22 did not receive services because of staffing concerns. LPN #2 stated she met with therapy staff and Restorative Nursing Assistants monthly to review Resident #22's progress in the restorative nursing program. She was unable to provide her monthly assessments for the restorative nursing program for Resident #22. LPN #2 was unaware Resident #22's care plan did not include a restorative nursing program. 2. Resident #24 was readmitted to the facility on 9/27/17, with diagnoses which included Parkinson's disease, contracture to the left knee, left hip, right hip, right knee, and multiple sclerosis. A quarterly MDS assessment, dated 5/11/18, documented Resident #24 had a moderate cognitive impairment. The MDS assessment documented she was totally dependent on 1 to 2 staff members for all cares. The MDS assessment documented she had bilateral functional range of motion impairments in her upper and lower extremities. The MDS assessment documented she participated in 1 day of passive range of motion and 1 day of	F 688	and implemented. Adjustments have been made as indicated. Facility Systems Licensed nurses and CNAs are educated to implementation of a resident restorative nursing program. Re-education was provided by the Chief Nursing Officer to include but not limited to, to validation that treatment and services for a restorative nursing program are planned, received, and documented. The system is amended to include review of restorative documentation to programs in clinical meeting. Monitor The Chief Nursing Officer and/or designee will audit 5 residents to validate treatment and services for a restorative nursing program were received, weekly for 4 weeks, then 2 residents weekly for 8 weeks. Starting the week of August 30, 2018, the review will be documented on the QAPI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.	

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F 688	Continued From page 53 splint/brace assistance. Resident #24's July 2018 Physician's Medication Order Summary Report documented on 4/30/18, she was to be evaluated for, and treated by, an RNA Program. Resident #24's care plan did not include a restorative nursing program. The 5/1/18 through 7/11/18 ADL Record documented Resident #24 was to be provided assistance putting her splint and brace on in the morning and the palm guard on in the evening. She was to be provided 15 minutes of PROM to the upper extremities and hands. The ADL documentation showed the restorative nursing assistant did not provide Resident #24 assistance with the brace 128 out of 144 opportunities. The ADL documentation showed Resident #24 was not provided passive ROM to her bilateral upper extremities and hands 131 out of 144 opportunities. On 7/9/18 at 2:44 PM and 4:19 PM, 7/10/18 at 9:13 AM, and 7/11/18 at 9:20 AM, Resident #24 was observed wearing palm guards. On 7/12/18 at 9:41 AM, LPN #2 and CNA #3 stated Resident #24's hand braces were not used because Resident #24's hands were contracted. CNA #3 stated Resident #24 refused restorative nursing services at times and she left the documentation blank instead of documenting refusals. LPN #2 stated she met with therapy staff and Restorative Nursing Assistants monthly to review Resident #24's progress in the restorative nursing program. She was unable to	F 688		

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F 688	Continued From page 54 provide the May and June 2018 monthly assessments for the restorative nursing program for Resident #24. On 7/12/18 at 10:41 AM, the DNS stated there should be a care plan for restorative nursing services to include monitoring Resident #24's skin under the braces at least once a day to check for signs of skin breakdown. The DNS stated the staff should be completing Resident #24's ROM programs and should be monitoring her skin under the braces. The DNS stated if Resident #24 was refusing the restorative nursing program staff should have notified the physician to discontinue restorative service and try other alternatives. 3. Resident #17 was admitted to the facility on 4/4/08, with diagnoses which included muscle weakness and osteoarthritis. A quarterly MDS assessment, dated 9/23/16, documented Resident #17 required extensive assistance from 1 to 2 staff members for all cares and had bilateral upper and lower ROM impairments in his extremities. A quarterly MDS assessment, dated 4/10/18, documented Resident #17 required extensive assistance from 1 to 2 staff members for all cares and was without ROM impairments. A quarterly MDS assessment, dated 5/1/18, documented Resident #17 had a moderate cognitive impairment. The MDS assessment documented he was totally dependent on 1 to 2 staff members for all cares. The MDS assessment documented he had bilateral range	F 688		

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F 688	Continued From page 55 of motion impairments in his upper and lower extremities. Resident #17's care plan did not include a restorative nursing program. On 7/9/18 at 2:31 PM, Resident #17 was observed in bed with contractures at his wrists and his legs would not straighten to a 180 degree angle. Resident #17 was observed again on 7/10/18 at 10:32 AM, 10:35 AM, 10:49 AM, 1:58 PM, and on 07/12/18 at 10:17 AM with the contractures. On 7/9/18 at 3:48 PM, LPN #3 stated Resident #17 should be receiving restorative nursing services for his hands because his hands had range of motion impairments. On 7/12/18 at 10:05 AM, LPN #2 stated Resident #17 was not on a restorative nursing program and Resident #17 did not have an ADL decline that he required a restorative nursing program for. LPN #2 stated Resident #17 did not have a ROM impairment in either his upper or lower extremities. LPN #2 stated she did not know how Resident #17's MDS assessments documented a decline in his ADLs. LPN #2 stated she watched Resident #17 closely. On 7/12/18 at 10:17 AM, the MDS Assistant was observed assessing Resident #17's ROM in his bilateral upper and lower extremities. The MDS Assistant stated she did not perform the assessments on 4/10/18 or 5/1/18 for Resident #17. The MDS Assistant stated based on her evaluation and Resident #17 being unable to straighten his wrists and his knees, her	F 688		

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CANYON WEST OF CASCADIA	2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605

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F 688	Continued From page 56 assessment was that he had bilateral upper and lower ROM impairments in his extremities. The MDS Assistant stated it would not hurt if Resident #17 was picked up by the restorative nursing program or therapy services. On 7/12/18 at 10:55 AM, the DNS stated when a resident had a decline in ADLs they should be placed on a restorative nursing program and/or receive an evaluation from physical therapy and/or occupational therapy. On 7/12/18 at 9:39 AM, LPN #2 stated she was the restorative nurse and also worked as a floor nurse. LPN #2 stated she had two restorative aides that provided treatment and services six days a week. LPN #2 stated one restorative aide was scheduled three 12 hour shifts and the other one was scheduled to work two 12 hour shifts. LPN #2 stated the program was not successful because the restorative aides were pulled to work the floor as CNAs. LPN #2 stated after reviewing care plans on residents, the program could benefit from more hours dedicated to the restorative nursing program. On 7/12/18 at 9:40 AM, CNA #3 stated residents were not provided restorative nursing services because she was pulled so often to work the floor.	F 688		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical	F 690		8/30/18

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F 690	Continued From page 57 condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on staff interview, review of the facility's bowel care protocol, and record review, it was determined the facility failed to consistently monitor bowel function for residents in accordance with standard nursing practice. This was true for 1 of 1 residents (#24) assessed for ordered bowel regimen. The facility failed to	F 690	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Canyon West of Cascadia does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or	

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F 690	Continued From page 58 implement a bowel protocol order for Resident #24. Resident #24 had the potential for harm from constipation or impaction. Findings include: Resident #24 was readmitted to the facility on 9/27/17, with diagnoses which included Parkinson's disease, contracture to the left knee, left hip, right hip, right knee, and multiple sclerosis. A quarterly MDS assessment, dated 5/11/18, documented Resident #24 had a moderate cognitive impairment. The MDS assessment documented Resident #24 was totally dependent on 1 to 2 staff members for all cares. The care plan area addressing Resident #24's ADL care, revised 3/22/16, documented Resident #24 was totally dependent on 1-2 persons for cares. Resident #24's July 2018 Physician's Medication Order Summary Report documented the following orders: * Provide 30 ml of Milk of Magnesia as needed for constipation if Resident #24 did not have a bowel movement for 2 days. If no results within 12 hours then see the Dulcolax order, ordered 9/27/17. * Provide Dulcolax Suppository as needed for constipation if no results in 8 hours see fleet Enema order, ordered 9/27/17. * Provide 1 unit of a Fleet Enema as needed for constipation, ordered 9/27/17.	F 690	conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. Resident Specific The clinical management team reviewed resident #24 for bowel function. Routine bowel care is effective as provided. Nursing staff re-educated to documentation of bowel movements. Other Residents The clinical management team reviewed other residents for effectiveness of bowel program. Documentation is consistent. Resident care adjustments have been made as indicated. Facility Systems Licensed nurses and CNAs are educated to consistently monitor and document bowel function. Re-education was provided by the Chief Nursing Officer to include but not limited to, consistency of monitoring, documenting, and implementation of bowel regimen. The system is amended to include review of bowel monitoring and implementation of the bowel regimen in clinical meeting. Monitor The Chief Nursing Officer and/or designee will audit bowel function documentation and bowel regimen	

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F 690	Continued From page 59 Resident #17's Bowel Movement Record, dated 5/1/18 through 7/11/18, documented Resident #17's bowel movements. Resident #17's bowel record documented she did not have a bowel movement between 5/4/18 and 5/9/18 (6 days), 5/29/18 and 6/11/18 (14 days), 6/13/18 and 6/16/18 (4 days), and 6/22/18 and 7/9/18 (18 days). Resident #17's MAR from 5/1/18 through 7/11/18 documented as needed bowel medications were not administered during the periods of no bowel movements noted above. On 7/12/18 at 10:34 AM, the DNS and the Clinical Resource Nurse stated the facility had a bowel alert when residents did not have bowel movements after 2 days. The DNS stated after 2 days without a bowel movement, the staff should follow the bowel protocol of Milk of Magnesia, then a suppository, and lastly an enema. The DNS stated she would assume Resident #24 was having bowel movements, and the documentation was incorrect.	F 690	implementation for 5 residents weekly for 4 weeks, then 4 residents weekly for 8 weeks. Starting the week of August 30, 2018, the review will be documented on the QAPI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.	
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte	F 692		8/30/18

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F 692	Continued From page 60 balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and record review, it was determined the facility failed to ensure residents were consistently provided with adequate hydration to prevent dehydration. This was true for 1 of 4 residents (#24) reviewed for hydration concerns. The failure created the potential for harm if Resident #24 became dehydrated. Findings include: According to the Nutrition Care Manual "Methods for Estimating Fluid Requirements" from the Academy of Nutrition and Dietetics, adults within Resident #24's age range should consume 30 ml per kilogram of body weight per day. Using this calculation method, Resident #24 needed a total daily fluid intake of 1759 ml's. Resident #24 was readmitted to the facility on 9/27/17, with diagnoses which included Parkinson's disease, contracture to the left knee, left hip, right hip, right knee, and multiple sclerosis. A quarterly MDS assessment, dated 5/11/18, documented Resident #24 had a moderate	F 692	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Canyon West of Cascadia does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. Resident Specific The ID team reviewed resident #24 and implemented a plan for hydration. Other Residents The ID team reviewed other residents who are on nectar thick fluids to validate adequate hydration plans are implemented to prevent dehydration. Adjustments have been made as indicated.	

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F 692	Continued From page 61 cognitive impairment. The MDS documented she was totally dependent on 1 to 2 staff members with all cares. The care plan area addressing Resident #24's ADL care, revised 3/22/16, documented Resident #24 was totally dependent on staff for eating and drinking. Resident #24's July 2018 Physician's Medication Order Summary Report documented she was to receive a puree texture with nectar thick liquids, ordered 9/27/17. The physician's orders documented Resident #24 was to receive 90 ml of a fortified shake four times a day at nectar thick consistency, ordered 11/15/17. The 7/1/18 through 7/10/18 ADL Report, Fluid Intake, documented Resident #24's fluid intake with meals. Resident #24's 7/1/18 through 7/10/18 MAR documented additional fluid intake. Resident #24 received the highest total fluid intake of 1140 ml on 7/9/18. Resident #24 received the lowest total fluid intake of 270 ml on 7/1/18. Resident #24's average fluid intake for the dates above was 770 ml's. The 7/1/18 through 7/10/18 MAR, documented Resident #24's fluid output. Resident #24's highest fluid output of 1075 ml on 7/10/18. Resident #24 lowest fluid output of 350 ml on 7/8/18. Resident #24's average fluid output for the dates above was 698 ml's. Resident #24's ADL Reports, dated 5/1/18 through 6/30/18, documented similar findings in the Fluid Intake section.	F 692	Facility Systems Licensed nurses and CNAs are educated to provide adequate hydration to prevent dehydration. Re-education was provided by the Chief Nursing Officer to include but not limited to, the process for providing thickened beverages at the bedside, fluid provision with care contact, monitor for adequate hydration, and plan to prevent dehydration. The system is amended to include monitoring on department manager room rounds, nursing supervisor rounds, and review with change of condition. Monitor The Chief Nursing Officer and/or designee will audit 5 residents with thickened beverages for adequate hydration weekly for 4 weeks, then 2 residents weekly for 8 weeks. Starting the week of August 30, 2018, the review will be documented on the QAPI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.	

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F 692	Continued From page 62 On 7/9/18 at 2:44 PM, Resident #24 stated she was thirsty when asked if she was having a good day. Resident #24's call light was located on her chest and she attempted to raise her arms and activate her call light but was unable to. Resident #24's catheter bag was observed with scant amounts of fluids in it. A staff member was made aware of Resident #24's thirst. On 7/9/18 at 2:50 PM, LPN #3 provided thickened fluids for Resident #24. Resident #24 drank 11 oz due to her thirst. On 7/10/18 from 9:04 AM through 10:05 AM, Resident #24 was observed in the hallway with her mouth dry and crusty and white strands between her lips when she parted her lips. On 7/12/18 at 10:49 AM, the DNS and Clinical Resource Nurse stated the staff should be offering fluids with all interactions and cares and staff should interact with all residents at least every 2 hours.	F 692		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, and review of residents' clinical records, it was determined the facility failed to	F 697	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction,	8/30/18

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F 697	Continued From page 63 ensure a method for evaluating the effectiveness of residents' pain management plans was in place. This was true for 1 of 2 residents (#20) sampled for pain. Resident #20 was harmed when she experienced increased pain during cares and a dressing change and the facility did not identify and treat it. Findings include: Resident #20 was readmitted to the facility on 12/27/15, with diagnoses which included chronic pain, osteoarthritis, spinal stenosis, and dementia without behavioral disturbances. A quarterly MDS assessment, dated 5/7/18, documented Resident #20 had a severe cognitive impairment. The MDS assessment documented she was totally dependent or required extensive assistance from 1 to 2 staff members for all cares except eating. The MDS assessment documented she was interviewed about pain and did not have the presence of pain. The care plan area addressing Resident #20's acute and chronic pain related to arthritis, initiated 11/12/12, documented staff were to administer medications as ordered and anticipate Resident #20 for pain relief and respond to her complaints of pain. The care plan area addressing Resident #20's wound infection to the left lower leg, initiated 7/9/18, documented Resident #20 experienced signs and symptoms of a wound infection. Resident #20's physician's orders included: * Tylenol 650 mg by mouth every 4 hours as	F 697	Canyon West of Cascadia does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. Resident Specific The clinical management team reviewed resident #20 and implemented a pain management plan, as well as a plan to validate pre-medication is effective prior to wound treatment. The physician orders, care plan, and monitoring have been updated. Other Residents The clinical management team reviewed other residents with evidence of pain for an effective pain management plan. Adjustments have been made as indicated. Facility Systems Licensed nurses and CNAs are educated to validate pain management plans are effective. Re-education was provided by the Chief Nursing Officer to include but not limited to, verbal and non-verbal signs of pain to include scratching/rubbing of the area, pre-medication for treatments as indicated, pain with cellulitis/infection, anticipation of residents who may experience additional pain, and how to be	

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F 697	Continued From page 64 needed for pain, ordered 9/2/16. * Pain Monitor using verbal and non-verbal 0-10 scale every shift, ordered 8/26/17. Resident #20 did not have orders for scheduled pain medications. The Weekly Skin Alteration Reports and Patient Infection Reports documented the following: * Weekly Skin Alteration Reports, dated 5/9/18, 5/16/18, 5/23/18, and 6/13/18, documented Resident #20 had a skin tear to the back of her left lower leg, first observed 4/30/18. The reports documented Resident #20's pain settled down as soon as her dressing changes were completed. * A Weekly Skin Alteration Report, dated 5/30/18, documented Resident #20 had a skin tear on the front of her left lower leg, first observed 4/30/18. The report documented Resident #20's only complained of pain during dressing changes. * A Patient Infection Report, dated 6/1/18, documented Resident #20 developed cellulitis (potentially serious bacterial skin infection) with heat, redness, swelling, serous (clear, thin, watery) drainage at the site, and was on antibiotic therapy. * A Weekly Skin Alteration Report, dated 6/6/18, documented Resident #20 had a skin tear of red granulation tissue with white slough (dead tissue, usually cream or yellow in color) throughout on the back of her right lower leg, first observed 4/30/18. The report documented Resident #20's pain resolved with the completion of the dressing changes.	F 697	a resident advocate for management of pain. Licensed nurses are educated that residents receiving wound care may need pre-medication. If the resident complains of pain, the nurse is to stop the treatment until pain can be controlled. In addition, licensed nurses review routine pain monitoring trend reports and use of PRN pain medications, update the physician, and determine if a routine pain medication maybe more effective. The system is amended to include review of pain management for residents with wounds in weekly wound rounds. In addition, PRN use for pain medications is reviewed in clinical meeting. Monitor The Chief Nursing Officer and/or designee will audit for effectiveness of residents' pain management plans to include pre-medication to wound treatment for 5 residents weekly for 4 weeks, then 2 residents weekly for 8 weeks. Starting the week of August 30, 2018, the review will be documented on the QAPI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The Clinical Resource RN (mentor and consultant) will validate quality with monthly review and trending for QAPI. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.	

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F 697	Continued From page 65 * A Weekly Skin Alteration Report, dated 7/6/18, documented Resident #20 had three wounds on her left lower leg, first observed on 4/40/18. She had one wound on the anterior (front) of her left lower leg 5 cm by 3.5 cm, a 4 cm by 2.5 cm wound on the posterior (back) of her left lower leg, and a 0.7 cm by 0.7 cm wound on her lateral (side) left lower leg. The report documented slough was present on the anterior and posterior wounds with odor, purulent (pus) discharge, signs and symptoms of infection, and the wound progression had deteriorated. * A Patient Infection Report, dated 7/6/18, documented Resident #20 developed cellulitis with heat, redness, swelling, presence of pus at the wound site, and was on antibiotic therapy related to wound infection of the lower leg and signs and symptoms of infections. Resident #20's Tubigrips (elastic tubular compression bandages) were observed bunched up on her legs as follows: * On 7/10/18 at 2:17 PM, Resident #20 was observed in bed with Tubigrips on both legs. The Tubigrips were rolled down and bunched on her right leg leaving an indentation where the bunching was localized. CNA #7 and CNA #6 did not notice the bunched Tubigrips and did not correct the stockings. * On 7/10/18 at 6:36 PM, Resident #20 was observed sitting in her wheelchair in the hallway. Resident #20 had her pants hiked up her legs to her knee and her left leg was red and irritated looking. Resident #20's right leg looked purple in	F 697		

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F 697	Continued From page 66 color and the Tubigrip remained bunched up and the front of her right leg was scratched. * On 7/10/18 at 6:43 PM, LPN #4 assessed Resident #20's right and left leg. Resident #20's Tubigrip on her right leg was bunched up and front of her leg was scratched and bleeding. LPN #4 stated she needed to remove Resident #20's Tubigrip on her right leg because it was bunched up and the Tubigrip caused an indentation into her leg. LPN #4 stated the nursing staff were responsible for placing and removing the Tubigrips on Resident #20. LPN #4 stated nursing staff monitored Resident #20's Tubigrips for functionality and the CNAs should report to nursing if the stockings were bunched and correct the stockings to prevent pressure points. * On 7/11/18 at 10:47 AM, Resident #20 was observed in bed with her Tubigrips bunched on her right leg leaving an indentation where the bunching was localized. The Clinical Resource Nurse corrected the bunched Tubigrips. * On 7/11/18 at 1:54 PM, Resident #20 was observed being assisted into bed by CNA #2 and CNA #4 with a Hoyer lift and her Tubigrip on her right leg was bunched up. CNA #2 and CNA #4 assisted Resident #20 into bed for a nap and change her soiled briefs. While CNA #2 and CNA #4 assisted her with cares and rolled her from side-to-side she moaned out and continued to moan out throughout the process. On 7/11/18 at 1:54 PM Resident #20's roommate stated Resident #20 was in pain often at night and when staff interacted with her during cares. Resident #20's roommate stated Resident #20	F 697		

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F 697	Continued From page 67 scratched herself because she was in pain. Resident #20's roommate stated a baby doll occupied Resident #20's hands so she did not scratch herself due to pain. On 7/11/18 at 2:06 PM, LPN #1 stated Resident #20's Tubigrips were bunched up and an indentation was present on the right and left leg. LPN #1 began the process of the dressing change of the two bandages on Resident #20's left leg. LPN #1 asked CNA #7 to assist her with the dressing change by holding Resident #20's leg in place. LPN #1 removed Resident #20's Tubigrips from her left leg and removed the soiled bandages. While Resident #20's bandages were removed she grimaced in pain and cried, "Owww." LPN #1 began cleansing the wounds with cleanser and removed her gloves once she completed the process. LPN #1 did not perform hand hygiene before placing new gloves on her hands. While Resident #20's wound was being cleansed she was crying out, "Quit it." "Get your damn." Resident #20 was pulling her leg back and trying to get her leg out of CNA #7 hands. LPN #1 removed a tube of Santyl from her pocket and opened the tube and applied and spread the ointment to the wound base using the end of the tube. While LPN #1 spread the ointment on Resident #20's wounds base she continued to cry and pull her leg back. Resident #20 was covering her face with her blanket and crying. LPN #1 asked Resident #20 if the dressing change was that bad and Resident #20 shook her head yes. On 7/11/18 at 2:20 PM, LPN #1 stated Resident #20 did not receive routine pain medications and this dressing change was the worst interaction	F 697		

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F 697	Continued From page 68 she had seen Resident #20 experience. LPN #1 stated she had not offered PRN pain medications prior to the dressing change and she would next time. On 7/11/18 at 2:37 PM, LPN #5 adjusted Resident #20's Tubigrips and Resident #20 cringed while her leg was being touched. On 7/11/18 at 5:07 PM, the DNS stated nursing staff were to ensure residents were not in pain and that residents were comfortable. The DNS stated nurses should offer PRN pain medications prior to dressing changes and if a resident demonstrated and/or verbalized pain during the dressing change the staff should stop. The DNS stated Resident #20 was not receiving scheduled pain medications and she did not receive a PRN pain medication dose on 7/11/18, prior to or during the dressing change.	F 697		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following	F 725		8/30/18

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F 725	Continued From page 69 types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review, and facility policy and procedure review, it was determined the facility failed to ensure there were sufficient numbers of nursing staff to meet the bathing, oral care, and restorative nursing needs of resident. This was true for 7 out of 16 (#17, #20, #22, #24, #27, #41, and #44) whose ADL needs were reviewed and had the potential to impact the other 45 residents residing in the facility. This systemic failure placed residents at risk of harm due to embarrassment, isolation, skin impairments, decline in oral health, and reduced mobility and independence. Findings include: The facility's Sufficient Qualified Nurse Staffing policy and procedure, dated 11/28/17, documented "Sufficient qualified nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of	F 725	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Canyon West of Cascadia does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. Resident Specific The clinical management team reviewed resident #17, 20, 22, 24, 27,41, and 44 to validate sufficient numbers of nursing staff to meet bathing, oral care, and restorative nursing needs of each resident. No adjustments were indicated; however, a plan to address resident care needs when line staff are unavailable has been developed.	

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F 725	Continued From page 70 care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the required facility assessment...The facility provides licensed nurses and other personnel, including but not limited to nurse aides, on a 24-hour basis in sufficient numbers to provide nursing cares to all resident in accordance with resident care plans." 1. Resident #41 was readmitted to the facility on 6/4/18, with multiple diagnoses, which included cerebrovascular accident (stroke). Resident #41's quarterly MDS assessment, dated 5/7/18, documented her cognition was severely cognitively impaired and was totally dependent on two staff members with bathing. Resident #41's June 2018 ADLs Report documented her bathing schedule was every Monday, Wednesday, and Friday. Resident #41 did not receive a bath on 6/6/18, 6/8/18, 6/11/18, 6/13/18, 6/15/18, 6/18/18, 6/20/18, 6/22/18, 6/27/18, and 6/29/18. Resident #41 received 2 baths out of 11 baths scheduled for the month of June. Resident #41's July 2018 ADLs Report, documented she received 2 baths out of 4 baths scheduled from 7/1/18 to 7/9/18. On 7/10/18 at 10:34 AM, upon entering Resident #41's room, a fish like odor was noted. The odor was more pronounced closer to Resident #41's bed. On 7/10/18 at 11:48 PM, two surveyors entered Resident #41's room. Both surveyors noticed the	F 725	Other Residents The clinical management team reviewed other residents for staff availability to meet their needs. Staffing patterns indicate that there is staff scheduled and available to meet the needs of the resident's current conditions; however, a plan to address resident care needs when line staff are unavailable has been developed. Facility Systems The Chief Nursing Officer, licensed nurses, and staffing coordinator are educated to adequate staffing requirements. Re-education was provided by the Clinical Resource RN and/or Director of Operations to include but not limited to, communication regarding staff attendance, resident change of conditions, and alternative plans for meeting staffing needs. The system is amended to document alternate processes attempted to meet resident needs and final plan implemented. In addition, staffing needs will be reviewed in resident council and upon staff interview for perceived staffing changes. Monitor The Chief Executive Officer (licensed administrator) and/or designee will audit staffing schedules prior to use and post implementation each morning for 4 weeks to validate resident needs are met with adequate staffing. In addition, review of resident and staff response to staffing needs will be monitored beginning August	

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F 725	Continued From page 71 fish like odor upon entering the room and noticed it was more pronounced near Resident #41's bed. On 7/10/18 at 11:51 AM, CNA #11 said due to two nose injuries she could not recognize the smell in Resident #41's room. On 7/10/18 at 11:51 AM, RN #2 said Resident #41 needed to be groomed. RN #2 said the CNAs gave baths to the residents and she did not know why Resident #41 did not receive her baths as scheduled. 2. Resident #24 was readmitted to the facility on 9/27/17, with diagnoses which included Parkinson's disease, contracture to her left knee, left hip, right hip, right knee, and multiple sclerosis. A quarterly MDS assessment, dated 5/11/18, documented Resident #24 had a moderate cognitive impairment. The MDS assessment documented she was totally dependent on 1 to 2 staff members for all cares. The care plan area addressing Resident #24's ADL care, revised 3/22/16, documented Resident #24 required 1 staff member's assistance with bathing and did not specify how many staff members she required for personal hygiene. a. The 5/1/18 through 7/11/18 ADL Report documented Resident #24 was to be provided oral care twice daily. The ADL documentation showed staff did not provide assistance with oral care 36 out of 143 opportunities.	F 725	30, 2018 the review will be documented on the audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The Director of Operations will validate quality with bi-monthly/monthly review and trending for QAPI. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.	

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F 725	Continued From page 72 b. On 7/9/18 at 2:44 PM through 4:16 PM, Resident #24 was observed with stringy like greasy hair. The 5/1/18 through 7/11/18 ADL Report documented Resident #24 was to be provided showers Wednesdays and Saturdays. The ADL documentation showed Resident #24 received a shower on 5/16/18 and was not provided a shower on 5/19/18. Resident #24's next shower was on 5/23/18, 6 days later. Resident #24 was not provided a shower on 5/26/18 and her next shower was provided on 5/30/18, 6 days later. Resident #24 received a shower on 6/2/18 and refused a shower on 6/6/18, was not provided a shower on 6/9/18, and received her next shower on 6/13/18, 10 days later. Resident #24 was not provided a shower on 6/16/18 and 6/20/18 and her next shower was on 6/22/18, 9 days later. Resident #24 received a shower on 6/29/18, refused a shower on 7/30/18, did not receive a shower on 7/4/18, and her next shower was on 7/7/18, 8 days later. Additionally, there was no documentation Resident #24 was reapproached or offered a shower the next day when she refused showers. On 7/12/18 at 10:28 AM, the DNS state the oral care and the showers should be completed as scheduled. c. Resident #24's care plan did not include a restorative nursing program. The 5/1/18 through 7/11/18 ADL Record documented Resident #24 was to be provided assistance putting her splint and brace on in the morning and the palm guard on in the evening.	F 725		

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F 725	Continued From page 73 She was to be provided 15 minutes of PROM to the upper extremities and hands. The ADL documentation showed the restorative nursing assistant did not provide Resident #24 assistance with the brace 128 out of 144 opportunities. The ADL documentation showed Resident #24 was not provided passive ROM to her bilateral upper extremities and hands 131 out of 144 opportunities. On 7/9/18 at 2:44 PM and 4:19 PM, 7/10/18 at 9:13 AM, and 7/11/18 at 9:20 AM, Resident #24 was observed wearing palm guards. On 7/12/18 at 10:41 AM, the DNS stated there should be a care plan for restorative nursing services to include monitoring Resident #24's skin under the braces at least once a day to check for signs of skin breakdown. The DNS stated the staff should be completing Resident #24's ROM programs and should be monitoring her skin under the braces. 3. Resident #22 was readmitted to the facility on 9/1/17 with multiple diagnoses, including a contracture to the left hand and dementia. A quarterly MDS assessment, dated 5/9/18, documented Resident #22 was severely cognitively impaired, required extensive assistance from two people, and had limited ROM impairments in both upper and lower extremities. Resident #22's July 2018 Physician's Medication Order Summary Report, on 4/16/17 documented, "RNA" (Restorative Nursing Assistant).	F 725		

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F 725	Continued From page 74 Resident #22's care plan did not include a restorative nursing program. Resident #22's 7/1/18 - 7/11/18 ADL Record documented the RNA provided passive ROM to her bilateral upper and lower extremities 2 out of 22 opportunities; 1 out of 22 opportunities were documented "not applicable"; and 19 out of 22 opportunities were left blank. On 7/12/18 at 9:12 AM, the DNS stated Resident #22 should have received 15 minutes of passive ROM to her bilateral upper and lower extremities and the blanks indicated the restorative therapy was not completed. The DNS stated Resident #22 did not receive treatment and services from the restorative nursing assistants because they were pulled to work the floor. 4. Resident #17 was admitted to the facility on 4/4/08, with diagnoses which included muscle weakness and osteoarthritis. A quarterly MDS assessment, dated 5/1/18, documented Resident #17 had a moderate cognitive impairment. The MDS assessment documented he was totally dependent on 2 staff members for all cares except eating and for personal hygiene he was dependent on assistance from 1 person. The MDS assessment documented he had bilateral range of motion impairments to his upper and lower extremities. The care plan area addressing Resident #17's ADL care, revised 4/4/08, documented Resident #17 required the assistance of 1 staff member for bed mobility, bathing, personal hygiene, and dressing.	F 725		

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F 725	Continued From page 75 The 5/1/18 through 7/11/18 the ADL Record documented Resident #17 was to be provided oral care twice daily. The ADL Record documented staff did not provide assistance with oral care 35 out of 143 opportunities. On 7/11/18 at 5:00 PM, the DNS stated oral care should be completed twice daily. 5. Resident #20 was readmitted to the facility on 12/27/15, with diagnoses which included dementia without behavioral disturbances. A quarterly MDS assessment, dated 5/7/18, documented Resident #20 had a severe cognitive impairment. The MDS assessment documented she was totally dependent or required extensive assistance of 1 to 2 staff members for all cares except eating. The care plan area addressing Resident #20's ADL care, revised 11/12/12, documented Resident #20 required 1 staff member's assistance with personal hygiene and dressing. The 5/1/18 through 7/11/18 ADL Report documented Resident #20 was to be provided oral care twice daily. The ADL Report documented staff did not provide Resident #20 assistance with oral care 32 out of 143 opportunities. On 7/11/18 at 5:00 PM, the DNS stated oral care should be completed twice daily. 6. Resident #44 was admitted to the facility on 6/1/18 with multiple diagnoses, including	F 725		

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F 725	Continued From page 76 hypertension and a urinary tract infection. The admission MDS assessment, dated 6/8/18, documented Resident #44 was moderately cognitively impaired and required total assistance from one person for personal hygiene, including toothbrushing. The 14-day MDS assessment, dated 6/15/18, documented Resident #44 was cognitively intact and required limited assistance from one person for personal hygiene, including toothbrushing. On 7/9/18 at 2:52 PM, Resident #44 stated the facility had not provided a toothbrush or toothpaste, since she was admitted to the facility (6/1/18). Resident #44 stated she was able to brush her own teeth independently, if she had the supplies to do so. Resident #44's care plan, dated 7/7/18 documented, "[Resident #44] requires set up assistance with personal hygiene." Resident #44's June 2018 ADL Report for personal hygiene, including toothbrushing, documented 28 out of 59 opportunities she required assistance; 21 out of 59 opportunities she was independent; and 10 out of 59 opportunities were left blank. Resident #44's July 2018 ADL Report for personal hygiene, including toothbrushing, documented 6 out of 22 opportunities she required assistance; 13 out of 22 opportunities she was independent; and 3 out of 22 opportunities were left blank.	F 725		

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F 725	Continued From page 77 On 7/11/18 at 11:47 AM, CNA #2 stated Resident #44 was independent with her ADL's including brushing her own teeth. CNA #2 asked Resident #44 where she stored her toothbrush and toothpaste and Resident #44 stated, "I don't have any and never have" and denied CNA #2 approval to look through her 3 drawer nightstand. CNA #2 brought a toothbrush and toothpaste to Resident #44 and Resident #44 allowed her to place them in her nightstand. CNA #2 was unable to find a toothbrush or toothpaste in Resident #44's 3 drawer night stand. On 7/11/18 at 1:41 PM, the DNS and the Clinical Resource Nurse stated the Admission Coordinator was the person that provided toiletries to newly admitted residents. On 7/11/18 at 1:46 PM, the Administrator stated the Admission Coordinator did not always provide toiletries to new residents. On 7/11/18 at 2:06 PM, the Admission Coordinator stated she made sure the new resident's room was ready and the CNA assigned to the hallway was responsible to provide the toiletries to the new resident. On 7/11/18 at 2:12 PM, CNA #10 stated when a new resident arrived her responsibilities were to check the new resident's vital signs and weight. CNA #10 stated the central supply person provided the toiletries to new residents. On 7/11/18 at 2:29 PM, the DNS stated the central supply person only worked two days a week and was not available for interview. The DNS and the Clinical Resource Nurse, also	F 725		

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F 725	Continued From page 78 present, stated they needed to work on a better system to communicate responsibilities for new residents. The DNS was unaware the CNAs were documenting Resident #44 required assistance with personal hygiene and Resident #44 did not have a toothbrush or toothpaste until CNA #2 provided them on 7/11/18. 7. Resident #27 was admitted to the facility on 11/22/16 with multiple diagnoses, including end stage renal disease, and diabetes mellitus with neuropathy. A quarterly MDS assessment, dated 5/16/18, documented Resident #27 was cognitively intact and required extensive assistance from two people for bathing. On 7/10/18 at 2:04 PM, Resident #27 stated she was provided a shower once a week and would like to have a shower two times a week. Resident #27's care plan, revised on 9/1/17, documented, "one staff assist with showers." The care plan did not include the days Resident #27 was scheduled to receive showers. The June and July 2018 ADL Reports documented Resident #27 was scheduled for showers on Tuesdays and Thursdays. The ADL Report documented Resident #27 received a shower on the following days: * 6/5/18 * 6/7/18 resident refused * 6/12/18 * 6/14/18 was left blank	F 725		

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	135051		07/13/2018

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F 725	Continued From page 79 * 6/19/18 * 6/21/18 resident refused * 6/26/18 * 6/28/18 was left blank * 7/3/18 * 7/5/18 resident refused * 7/10/18 On 7/12/18 at 5:03 PM, the DNS and Clinical Resource Nurse stated Resident #27 should have had showers twice a week and the care plan should be more specific on what days Resident #27 was scheduled for showers. The DNS stated when a resident refused a shower, the staff should offer one the next day. The DNS was unable to provide documentation Resident #27 was offered a shower the day following her refusals. Staff Interviews: On 7/12/18 at 9:13 AM, CNA #4 stated all CNAs assisted with showers and the computer provided a list of showers that needed completed for the day. CNA #4 stated there was not enough help to complete all the showers in the day and some residents' showers were not completed. The CNA stated if the documentation had blanks or the number 97 in the shower or oral care section it meant a shower or oral care was not completed that day. On 7/12/18 at 9:18 AM, CNA #9 stated there was not enough help to assist all the residents with showers and oral care. CNA #9 stated there were days when residents did not receive showers. CNA #9 stated oral care should be completed in the morning and at night and it did not always	F 725		

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F 725	Continued From page 80 happen, it depended on how many staff were working and if people called in. On 7/12/18 at 1:48 PM, CNA #5 stated residents had complained to her of not receiving their showers due to lack of CNA staff. CNA #5 stated she was to provide oral care daily after breakfast and lunch. CNA #5 stated the computer system provided the list of who required a shower for the day. On 7/13/18 at 11:35 AM, CNA #6 stated there were not enough CNAs to provide all the scheduled showers. CNA #6 stated oral care should be completed three times a day and this was not always completed. On 7/12/18 at 9:39 AM, LPN #2 stated she was the restorative nurse and also worked as a floor nurse. LPN #2 stated she had two restorative nursing aides that provided treatment and services six days a week. LPN #2 stated one restorative aide was scheduled three 12 hour shifts and the other one was scheduled to work two 12 hour shifts, with an additional aide hired that started later in July. LPN #2 stated she worked 4-12 hours per pay period and up to 24 hour a month but had been frustrated due to the restorative aides being pulled to work the floor. LPN #2 stated after reviewing residents' care plans, the restorative nursing program could benefit from more hours to make it successful. On 7/12/18 at 9:40 AM, CNA #3 stated residents were not provided restorative nursing services because she was pulled so often to work the floor.	F 725		

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F 725	Continued From page 81 On 7/12/18 at 9:12 AM, the DNS stated the restorative nursing aides had been pulled to work the floor because resident care came first. The DNS stated there was not enough staff to provide care specifically for the restorative nursing program and to complete showers and oral care for residents.	F 725		
F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents'	F 726		8/30/18

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F 726	Continued From page 82 needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review, and policy and procedures review, it was determined the facility failed to develop and implement a CNA and licensed nurse training program that provided an individual competency test/performance review upon hire. This was true for 25 out of 26 CNAs (#A-#Z) and 12 out of 18 (#AA-#LL) licensed nurses whose training information was reviewed. This failure affected all residents in the facility and increased the risk of harm to residents if CNAs and licensed nurses were not determined competent to provide care and services to residents. Findings include: The facility's Sufficient Qualified Nurse Staffing policy and procedure, dated 11/28/17, documented "Sufficient qualified nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the required facility assessment...The facility provides licensed nurses and other personnel, including but not limited to nurse aides, on a 24-hour basis in sufficient numbers to provide nursing cares to all resident in accordance with resident care plans." On 7/13/18 at 2:28 PM, the Staff Development Coordinator provided her education and	F 726	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Canyon West of Cascadia does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. Employee Specific The licensed nurses and CNAs (CNAs A-Z and LNs AA-LL) have been skills checked for individual clinical competency. Facility Systems The Chief Nursing Officer is educated to implement a CNA and licensed nurse training program that provides an individual competency test/performance review upon hire. Re-education was provided by the Chief Executive Officer to validate clinical competency after the employee introductory period upon hire and annually. Monitor The Chief Executive Officer and/or designee will audit new hires and those in	

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F 726	Continued From page 83 performance evaluation binders. Performance/competency information indicated as a result of a change of facility ownership, all licensed nurses and CNAs were hired between 9/1/17 to 7/3/18. The performance evaluation/competency testing information documented 25 of 26 CNAs (#A-#Z) and 12 of 18 (#AA-#LL) licensed nurses had not had a performance evaluation/competency test. On 7/13/18 at 2:48 PM, the Staff Development Coordinator stated the process was to provide the staff with a competency checklist/ performance evaluation upon hire and annually thereafter to determine staff competency levels. The Staff Development Coordinator stated the facility had not started the performance evaluations/competency checklists and was not currently up to date with all the nursing staff.	F 726	their annual review period for individual competency test/performance, weekly for 12 weeks if applicable. Starting the week of August 30, 2018, the review will be documented on the QAPI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse	F 757		9/4/18

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F 757	Continued From page 84 consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure residents receiving psychotropic medications were monitored consistently for side effects of the medications. This was true for 1 of 3 (#36) sampled residents who received psychoactive medications. This deficient practice created the potential for adverse consequences if residents received medications and were not monitored adequately. Findings include: 1. Resident #36 was admitted to the facility on 3/16/17, with multiple diagnoses which included anxiety and major depressive disorder. Resident #36's annual MDS assessment, dated 2/28/18, documented she was cognitively intact, had mild depression and received psychotropic medications daily. Resident #36's care plan initiated on 3/21/17, documented she had behavior problems related to refusing recommended treatment despite education or benefit, self-picking at skin, poor impulse control-addictive history (medications, alcohol, soda, candy), claiming missing clothing but denies ownership of clothes known to be hers and self-report of anxiety. Interventions included in the care plan were "Administer medications as ordered, Behavior monitoring, and report to MD	F 757	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Canyon West of Cascadia does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. Resident Specific The clinical management team reviewed resident #36, no side effects from the use of antidepressant and antianxiety medication was evident. Other Residents The clinical management team reviewed other residents for consistent monitoring for side effects of psychotropic medications. Adjustments were made as indicated. Facility Systems Licensed nurses are educated to monitor for side effects of psychotropic	

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F 757	Continued From page 85 [physician] as necessary side effects and adverse reactions of psychoactive medications" The resident's June 2018 recapitulated physician's orders included Cymbalta capsule delayed release 60 mg one capsule by mouth one time a day for depression, Seroquel tablet 100 mg one tablet by mouth one time a day for Bipolar Disorder, Wellbutrin XL (extended release) 24 hour 300 mg one tablet one time a day for depression, and Xanax tablet 0.25 mg four times a day for anxiety. The order also directed staff to monitor for Resident #36's behaviors and side effects of antidepressant medications. Resident #36's June 2018 Behavior Monitoring Flowsheet included space for documentation of her behaviors or lack thereof, and the presence or absence of side effects, day and night. Resident #36's June 2018 Behavior Monitoring Flowsheet, did not include documentation of the side effects of the medication on 7 of the 30 days during the day and 7 of the 30 days during the night. On 7/11/18 at 10:07 AM, the LSW (Licensed Social Worker) said Resident #36's target behavior and side effects of the medication should be monitored daily. If the monitoring flowsheet was blank it would not be counted. LSW said the lack of documentation in the Behavior Monitoring Flowsheet for the side effects meant the nurse did not document the presence or absence of the side effects.	F 757	medications. Re-education was provided by the Chief Nursing Officer to include but not limited to documentation of side effects for psychotropic medications, review of documentation with physician update as indicated. The system is amended to include review of side effect documentation in clinical meeting. Monitor The Chief Nursing Officer and/or designee will audit 5 resident records for documentation to the side effects of psychotropic medications, weekly for 4 weeks, then 2 resident records weekly for 8 weeks. Starting the week of August 30, 2018, the review will be documented on the QAPI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.	
F 825 SS=D	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2)	F 825		9/4/18

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F 825	Continued From page 86 §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure residents received rehabilitative services as ordered by a physician. This was true for 1 of 4 (#41) residents whose therapy services were reviewed. This failure created the potential for residents to experience decline in their physical functioning when rehabilitative services were not provided. Findings include: Resident #41 was admitted to the facility on 6/4/18, with multiple diagnoses, which included cerebrovascular accident (stroke). Resident #41's quarterly MDS assessment, dated	F 825	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Canyon West of Cascadia does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.	

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F 825	Continued From page 87 5/7/18, documented her cognition was moderately impaired and she required extensive assistance of two staff members with most ADLs and received OT (occupational therapy) 3 times a week. Resident #41's OT Plan of Care, documentation included: *The start of care was 6/28/18. *Therapy was necessary to develop a restorative program to prevent UE (upper extremities) contractures. *The goal for Resident #41 was to have an RNA program and caregiver will be trained to decrease her risk of joint contractures and maintain good skin integrity. *Resident #41's rehabilitation potential was good. *Treatment approaches included therapeutic exercises, therapeutic activities, OT evaluation, moderate complexity, and wheelchair assessment and management. *The certification period was 6/28/18 - 7/18/18, 3 times a week for 3 weeks. Resident #41's OT Daily Treatment Note, documented Resident #41 had OT on Thursday 6/28/18, Friday 7/6/18, and Monday 7/9/18. Resident #41 had one OT session for the week of 7/1/18 to 7/7/18 instead of three as outlined in her OT plan of care. On 7/11/18 at 11:22 AM, the Certified Occupational Therapy Assistant (COTA) said he did not know why Resident #41 had only one OT session for the week of 7/1/18 to 7/7/18. He said Resident #41 should have three OT sessions per week.	F 825	Resident Specific The ID team reviewed resident #41 to validate rehabilitative services are scheduled as ordered by the physician. Other Residents The ID team reviewed other residents to validate rehabilitative services are scheduled as ordered by a physician. No other adjustments were indicated. Facility Systems Licensed therapists are educated to schedule resident rehabilitative services as ordered by a physician. Re-education was provided by the Chief Executive Officer (license administrator) to include but not limited to, scheduling of residents to receive rehabilitative services as ordered by a physician. The system is amended to include review of rehabilitation coverage plans in advance of holidays. Monitor The Chief Executive Officer (licensed administrator) and/or designee will audit 5 resident records to validate residents received rehabilitative services as ordered by a physician weekly for 4 weeks, then 2 residents weekly for 8 weeks. Starting the week of August 30, 2018, the review will be documented on the QAPI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of	

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F 825	Continued From page 88 On 7/11/18 at 1:50 PM, the COTA said there was a "mixed up" in their scheduling. The main scheduler was off during the week of 7/1/18 to 7/7/18 due to the fourth of July holiday. When asked if they provides therapy during holidays, the COTA said, "Yes."	F 825	the monitoring after 12 weeks, as it deems appropriate.	
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations	F 838		8/30/18

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F 838	Continued From page 89 that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of the facility's asessment, it was determined the facility failed to ensure its Facility Assessment identified the resources and staffing to provide person centered care and services required by residents and lack of competency for nursing staff. This	F 838	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Canyon West of Cascadia does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility	

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F 838	Continued From page 90 was true for 7 out of 16 (#17, #20, #22, #24, #27, #41, and #44) residents reviewed for ADLs and restorative nursing services and had the potential to impact the other 45 residents residing in the facility. This created the potential for harm if the facility did not have the resources to provide the necessary care and services the residents required. Findings include: 1. The Facility Assessment, dated September 30, 2016 - September 30, 2017, documented the required assistance of 1 person for ADL's was rated low for daily cares, bed mobility, transfers, toilet use, and dressing; very low for bathing and hygiene/grooming. The Facility Assessment, dated September 30, 2016 - September 30, 2017, documented the required assistance for 2 persons for ADL's were rated low for daily cares, bed mobility, transfers, toilet use, dressing, and hygiene/grooming; very low for bathing. The Facility Assessment, dated September 30, 2016 - September 30, 2017, documented the nursing staff was sufficiently trained in ADL's, Mobility, Treatments, Acuity Diseases, Medications, Cognitive, Mental, Behavior Status, Cultural, Ethnic, and Religious Factors through a review of staff competencies and staff observation. On 7/13/18 at 4:36 PM, RN #1 stated the current census was 55 individual residents whom 11 residents required no assistance with care, 22 residents required 1 person assistance with cares, and 22 residents require 2 person assistance with cares.	F 838	admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. Resident Specific The clinical management team reviewed resident #17, 20, 22, 24, 27, 41, and 44 for resources and staffing to provide person centered care in ADLs and restorative nursing programs. Plans were implemented as noted in F725 and F726. Other Residents The clinical management team reviewed other residents for resources and staffing to provide person centered care in ADLs and restorative nursing programs. The facility assessment is adjusted for the current resident population to include resident needs for two-person transfers, restorative nursing services, and clinical competencies for license nurses and CNAs. Facility Systems The Chief Executive Officer (licensed administrator), Chief Nursing Officer, and the Interdisciplinary Team are educated to update the Facility Assessment for current resident population. Re-education was provided by the Director of Operations to include but not limited to, identification of residents that require two-person assistance, restorative nursing services,	

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F 838	Continued From page 91 On 7/13/18 at 4:13 PM, the Administrator stated the Facility Assessment needed to be updated to the current resident population and staff competencies more often than yearly. 2. Refer to F725 as it relates to the failure of the facility to ensure there were sufficient numbers of nursing staff to meet the bathing, oral care, and restorative nursing needs of resident. 3. Refer to F726 as it relates to the failure of the facility to ensure licensed nurses and CNAs received performance evaluations/competency tests to confirm they possessed the skills and abilities necessary to provide care and services to residents.	F 838	and clinical competencies for licensed nurses and CNAs on the Facility Assessment. The system is amended to include review of changes in current resident population and staffing patterns with QAPI meetings. The Facility Assessment will be updated as indicated. Monitor The Chief Executive Officer (licensed administrator) and Director of Operations will review and update the Facility Assessment and bring to QAPI committee. The QAPI committee will review to validate accuracy of current resident population and competency of nursing staff is addressed in the Facility Assessment.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented;	F 842		8/30/18

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F 842	Continued From page 92 (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident;	F 842		

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F 842	Continued From page 93 (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure a resident's transfer orders from the hospital were transcribed completely. This was true for 1 of 16 (#157) residents whose records were reviewed. This created the potential for negative outcome when Resident #157 order for a CPAP (continuous positive airway pressure) machine was not transcribed in the facility's admitting orders. Findings include: Resident # 157 was admitted to the facility on 3/28/17, with multiple diagnoses which included congestive heart failure and chronic obstructive pulmonary disease. Resident #157's Hospital Discharge Orders, dated 3/28/18 stated the resident had a diagnosis of obstructive sleep apnea and used a CPAP machine while sleeping. Resident #157's March 2018 recapitulated physician's orders did not include an order for the CPAP machine. Resident #157's care plan and TAR did not	F 842	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Canyon West of Cascadia does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. Resident Specific The ID team (clinical management team) reviewed resident #157. The resident is discharged. Other Residents The ID team (clinical management team) reviewed other residents for ensuring that resident's transfer orders were	

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F 842	Continued From page 94 include her use of the CPAP machine. An undated document which listed Resident #157's personal belongings included a CPAP machine. On 7/13/18 at 10:06 AM, the DNS reviewed Resident #157's Hospital Discharge Orders and said there was an order for a CPAP machine. She said when Resident #157's family brought the CPAP machine to the facility it should have been added to her physician orders.	F 842	transcribed completely. Adjustments have been made as indicated. Facility Systems Licensed nurses are educated to ensure that resident's transfer orders were transcribed completely. Re-education was provided by Chief Nursing Officer to include but not limited to, ensuring that resident's transfer orders were transcribed completely. Monitor The Chief Nursing Officer and/or designee will audit to ensure that resident's transfer orders were transcribed completely for 5 residents (as applicable) weekly for 4 weeks, then 2 residents (as applicable) weekly for 8 weeks. Starting the week of August 30, 2018, the review will be documented on the QAPI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880		8/30/18

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F 880	Continued From page 95 diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under	F 880		

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F 880	Continued From page 96 the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and policy review, it was determined the facility failed to ensure infection control measures were consistently implemented. This was true for 3 of 16 (#20, #22 and #41) residents reviewed for infection control when staff failed to wash a nebulizer face mask after it was used and perform effective hand hygiene during residents' cares and dressing changes. These deficient practices created the potential for harm by exposing residents to the risk of infection and cross contamination. Findings include: 1. Resident #20 was readmitted to the facility on 12/27/15, with diagnoses which included	F 880	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Canyon West of Cascadia does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.	

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F 880	Continued From page 97 dementia without behavioral disturbances. A quarterly MDS assessment, dated 5/7/18, documented Resident #20 had a severe cognitive impairment. The MDS assessment documented she was totally dependent or required extensive assistance of 1 to 2 staff members for all cares except eating. The MDS assessment documented she had skin tears. A previous quarterly MDS assessment, dated 2/4/18, documented she did not have skin tears or wounds. The care plan area addressing Resident #20's wound infection to the left lower leg, initiated 7/9/18, documented Resident #20 experienced signs and symptoms of wound infection. The care plan documented staff were to monitor and record the amount, color, and odor of wound drainage and provide treatments per physician orders. a. Resident #20 developed an infection in her wounds: * A Patient Infection Report, dated 6/1/18, documented Resident #20 developed cellulitis (potentially serious bacterial skin infection) with heat, redness, swelling, serous (clear, thin, watery) drainage at the site, and was on antibiotic therapy. * A Patient Infection Report, dated 7/6/18, documented Resident #20 developed cellulitis with heat, redness, swelling, presence of pus at the wound site, and was on antibiotic therapy related to wound infection of the lower leg and signs and symptoms of infections.	F 880	Resident Specific The clinical management team reviewed resident #20 who was treated for cellulitis, no additional infection has been identified. Resident #22 and 41 were assessed, no evidence of infection was identified related to hand hygiene and cleansing of the nebulizer face mask. Other Residents The clinical management team reviewed other residents to validate no infections were identified related to hand hygiene with personal cares and wounds, or lack of nebulizer mask cleansing. Rounds show evidence of proper hand hygiene and the nebulizer mask cleansing process. Facility Systems Licensed nurses are educated to infection control measures for respiratory equipment. Re-education was provided by Chief Nursing Officer to include but not limited to, cleansing a nebulizer face mask after use, allowing it to air dry, and then storing. Licensed nurses and CNAs are educated to performing effective hand hygiene during resident cares and dressing changes. Re-education was provided by Chief Nursing Officer to include but not limited to washing with changing of gloves, when removing items from a	

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F 880	Continued From page 98 On 7/10/18 at 6:36 PM, Resident #20 was observed sitting in her wheelchair in the hallway. Resident #20 had her pants hiked up her legs to her knee and her left leg was red and irritated looking. On 7/10/18 at 6:43 PM, the front of Resident #20's right leg was scratched and bleeding. b. On 7/11/18 at 1:54 PM, Resident #20 was observed being assisted into bed by CNA #2 and CNA #4 with a Hoyer lift. CNA #2 and CNA #4 assisted Resident #20 into bed for a nap and to change her soiled briefs. The two CNAs were changing her incontinence brief and CNA #2 changed her gloves after performing pericare. CNA #2 did not perform hand hygiene between glove changes. CNA #4 removed her gloves after completing pericare, removed the soiled trash bag, replaced the liner, and left with room without performing hand hygiene. On 7/11/18 at 1:59 PM, CNA #2 stated she should have performed hand hygiene between glove changes but forgot. On 7/11/18 at 2:06 PM, LPN #1 stated Resident #20's Tubigrip (elastic tubular compression bandages) on her right leg was bunched up and an indentation was present on the right and left leg. LPN #1 began the process of the dressing change of the two bandages on Resident #20's left leg. LPN #1 asked CNA #7 to assist her with the dressing change by holding Resident #20's leg in place. LPN #1 removed Resident #20's Tubigrips from her left leg and removed the soiled bandages. LPN #1 began cleansing the	F 880	uniform pocket, moving from a soiled area to a clean area, preventing contamination of tubes of creams, and touching of respiratory equipment. The system is amended to include surveillance rounding for infection control practices to include hand hygiene and respiratory equipment management. Monitor The Chief Nursing Officer and/or designee will complete surveillance audits of hand hygiene during dressing changes and cares, as well as cleansing of nebulizer face masks for 5 residents weekly for 4 weeks, then 2 residents weekly for 8 weeks. Starting the week of September 5, 2018, the review will be documented on the QAPI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.	

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F 880	Continued From page 99 wounds with cleanser and removed her gloves after she completed the process. LPN #1 did not perform hand hygiene before placing new gloves on her hands. LPN #1 removed a tube of Santyl from her pocket and opened the tube and applied and spread the ointment to the wound base using the end of the tube. On 7/11/18 at 2:20 PM, LPN #1 stated she should have washed her hands between moving from dirty to clean in the dressing change process. On 7/11/18 at 5:00 PM, the DNS stated the facility was aware of concerns with wound management and had a contract agency set up to manage wounds. The Clinical Resource RN stated Resident #20's leg got infected because she picked at the wound and removed the bandages. Resident #20's clinical record did not contain documentation she removed her bandages or picked at her wounds. The DNS stated during wound care nurses should perform hand hygiene, apply gloves, remove soiled bandages and cleanse the wounds, perform hand hygiene and apply fresh gloves. The DNS stated the nurse should use a Q-tip to apply the ointment onto the wound base and apply new bandages onto the wounds. The DNS stated the nurse should wash their hands after the process was completed. 2. Resident #41 was admitted to the facility on 6/4/18, with multiple diagnoses, which included cerebrovascular accident (stroke). Resident #41's quarterly MDS assessment, dated 5/7/18, documented her cognition was	F 880		

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F 880	Continued From page 100 moderately impaired and she required extensive assistance of two staff members with most ADLs. On 7/9/18 at 2:40 PM, LPN #6 removed the face mask (aerosol mask) from Resident #41's face after Resident #41 was done with her nebulization treatment. LPN #6 was observed to put the face mask inside a plastic bag without cleaning it, sanitized her hands, and left Resident #41's room. On 7/9/18 at 2:52 PM, LPN #6 said she put the face mask inside the plastic bag after Resident #41 was done with nebulization. When asked if she wash the face mask, LPN #6 said she did not wash the face mask. LPN #6 then asked RN #2 who was just walking by. RN #2 said the face mask should be washed after each use and air dried. LPN #6 she was not aware she needed to wash the face mask after each use. 3. Resident #22 was readmitted to the facility on 9/1/17 with multiple diagnoses, including contracture to the left hand and dementia. A quarterly MDS assessment, dated 5/9/18, documented Resident #22 was severely cognitively impaired and required extensive assistance with two people. On 7/10/18 at 1:25 PM, CNA #6 and CNA #8 were observed transferring Resident #22 to bed with the Hoyer lift. After peri care was finished, CNA #6 and CNA #8 removed their gloves and placed new gloves on to apply an incontinence brief and position Resident #22 in bed. CNA #6 stated she had been a CNA for 25 years and did not know she had to wash hands between glove	F 880		

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F 880	Continued From page 101 changes when performing personal care. CNA #8 stated she should have washed her hands between changing gloves. The facility's policy and procedure for Hand Hygiene/Handwashing, dated 11/2/17, documented, "Handwashing is the single most important procedure for preventing the spread of infection...Hand hygiene is to be performed: Intermittently after gloves are removed, between patient contacts, and when otherwise indicated to avoid transfer of microorganisms to other patients or environments and between tasks and procedures on the same patient when contaminated with body fluids to prevent cross-contamination of different body sites..."	F 880		
F 883 SS=F	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative	F 883		8/30/18

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F 883	Continued From page 102 was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review, and review of facility's policy and procedure for Pneumococcal Program, it was determined the	F 883	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135051		07/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON WEST OF CASCADIA	2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 103 facility failed to develop and implement processes to minimize the risk of residents acquiring, transmitting, or experiencing complications from Pneumococcal pneumonia (bacterial). The facility failed to implement an immunization program that tracked residents' Pneumococcal vaccine status so immunization could be offered or provided as indicated. This was true for 4 of 4 residents (#2, #20, #52 and #17) sampled for the Pneumococcal vaccination and had the potential to affect all residents residing in the facility. Findings include: The Centers for Disease Control and Prevention (CDC) website, updated 11/22/16, included recommendations for Pneumococcal vaccination (PCV 13 or Prevnar 13®, and PPSV 23 or Pneumovax 23®) for all adults 65 years or older that documented : * Adults 65 years or older who have not previously received PCV 13, should receive a dose of PCV 13 first, followed 1 year later by a dose of PPSV 23. *If the patient already received one or more doses of PPSV 23, the dose of PCV 13 should be given at least 1 year after they received the most recent dose of PPSV 23." The facility's Pneumococcal Program policy, released 10/31/17, documented: * Vaccines are available that can prevent two kinds of pneumonia: Pneumococcal conjugate vaccine (PCV 13 or Prevnar 13) and Pneumococcal polysaccharide vaccine (PPSV 23 or Pneumovax 23). These are recommended for	F 883	Canyon West of Cascadia does not admit that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. Resident Specific The clinical management team reviewed resident #2, 20, 52, and 17 for tracking of Pneumococcal vaccine status and immunization as indicated if resident consents. Other Residents The clinical management team established the pneumococcal vaccination log tracking system for other residents to determine which vaccine was received, when the next vaccination is due, and who refused the vaccines, and when they will be re-offered. Vaccines are administered as indicated. Facility Systems The Infection Preventionist is educated to implement an immunization program that tracks residents' Pneumococcal vaccine status. Re-education was provided by Chief Nursing Officer to include but not	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 883	Continued From page 104 adults over 65 and people with certain medical conditions to include chronic heart and lung disease, diabetes mellitus, liver disease, renal failure, smoking, alcoholism, immunodeficiency, cancers, and organ transplants, etc. * Administer the Pneumococcal vaccine, document on the medication administration record dosing, site, and lot number. The policy further stated: * If not previously received provide PCV 13 upon admission, then follow in greater than 8 weeks for high risk residents and greater than 1 year for other residents with Pneumococcal PPSV 23. * If previously received either PCV 13 or PPSV 23, then follow with the alternate immunization upon admission. * Residents should receive both Pneumococcal immunizations [greater than] 8 weeks apart for high risk residents and [greater than] one year for other residents. * Revaccination of PPSV 23 is recommended [greater than] five years after PPSV 23. * Update the resident's immunization record. 1. Resident #2 was admitted to the facility on 10/11/16, with multiple diagnoses, which included muscle weakness and diabetes mellitus. Resident #2's annual MDS assessment, dated 3/27/18, documented Resident #2 was "up to date" with the Pneumococcal vaccination.	F 883	limited to, implementing an immunization program that tracks residents' Pneumococcal vaccine status, determines when the next vaccination is due, and provides a schedule to re-offer to residents who refuse. The system is amended to utilize a tracking log for pneumococcal vaccinations. Monitor The Chief Nursing Officer and/or designee will audit the Pneumococcal vaccination tracking log and provision of immunizations for 5 residents weekly for 4 weeks, then 2 residents weekly for 8 weeks. Starting the week of September 5, 2018, the review will be documented on the QAPI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.	

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F 883	Continued From page 105 Resident #2's clinical record documented he received PPSV 23 on 2/6/17. The clinical record did not document if he received Prevnar 13. 2. Resident #20 was admitted to the facility on 12/27/15, with multiple diagnoses, which included dementia and hypertension. Resident #20's annual MDS assessment, dated 2/4/18, documented Resident #20 was "up to date" with the Pneumococcal vaccination. Resident #20's clinical record documented she received Pneumovax dose 2 on 2/23/12. The clinical record did not document if she received Prevnar 13. 3. Resident #52 was admitted to the facility on 1/31/17, with multiple diagnoses, which included diabetes mellitus and hypertension. Resident #52's annual MDS assessment, dated 9/8/17, documented Resident #52 was "up to date" with the Pneumococcal vaccination. Resident #52's clinical record documented she received PPSV 23 on 6/16/16. The clinical record did not document if she received Prevnar 13. 4. Resident #17 was admitted to the facility on 4/4/08, with multiple diagnoses, which included muscle weakness and hypertension. Resident #17's annual MDS assessment, dated 12/23/17, documented Resident #52 was "up to date" with the Pneumococcal vaccination.	F 883		

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F 883	Continued From page 106 Resident #17's clinical record documented he received Pneumovax dose 1. The clinical record did not document if he received Prevnar 13. On 7/12/18 at 8:21 AM, RN #2 showed a copy of residents' vaccination record. The vaccination record documented what vaccines were given to the residents, it did not document when the next vaccine was due. When asked if she was tracking the residents' immunizations, RN #2 said the residents' electronic medical record had all the vaccines the residents' received. RN #2 was unable to provide a tracking system that showed who received the vaccines, which vaccine was received, when the next vaccination was due, and who refused and the reason for the refusal. On 7/12/18 at 9:46 AM, the Clinical Resource Manager (CRM) provided a blank copy of the facility's Pneumococcal Tracking Log and said they would implement it immediately.	F 883		
F 919 SS=F	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, review of maintenance logs, and staff and resident interviews, it was determined the facility failed to ensure all call lights were functioning and the devices were	F 919	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Canyon West of Cascadia does not admit	8/30/18

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F 919	Continued From page 107 available. This was true for 2 of 17 residents (#31 and #43) reviewed for call lights and had the potential for harm if residents were unable to summon staff assistance by activating the call light. Findings include: 1. Resident #31 was admitted to the facility on 11/8/17 with multiple diagnoses, including hypertension. A quarterly MDS assessment, dated 5/24/18, documented Resident #31 was cognitively intact and was independent with ambulation. On 7/9/18 at 2:17 PM, Resident #31 was observed in his room without a call light. Resident #31 stated he had not had a call light for an extended period of time. Resident #31 stated he would ambulate with his front-wheeled walker to the door and ask for assistance. On 7/9/18 at 5:02 PM, Resident #31 was observed without a call light. On 7/9/18 at 5:03 PM, CNA #10 was observed looking for Resident #31 call light cord and stated there was a plug in the wall, but not a call light cord. On 7/9/18 at 5:06 PM, the DNS was observed looking for Resident #31's call light and stated there was a plug in the wall, but not a call light cord to be able to activate. On 7/9/18 at 5:33 PM, the Administrator stated the maintenance supervisor was new. The Administrator provided maintenance call system checks from November 2017 - May 2018. The	F 919	that the deficiencies listed on the CMS Form 2567L exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The Facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency. Resident Specific The ID team (clinical management team) reviewed resident #31 and #43 for call light cord availability and proper function of the call light system. Call lights are available and functioning. Other Residents The ID team (clinical management team) reviewed other residents for call light cord availability and proper function of the call light system. No additional missing or malfunctioning call lights were identified. Facility Systems Employees are educated to validate resident call light cords are available. Re-education was provided by the CEO to include but not limited to immediate report of any problems related to the function of the call light system to the Maintenance Director. If after hours, utilize an alternate functional call light and/or notify the Chief Executive Officer	

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F 919	Continued From page 108 Administrator was unable to provide documentation for June 2018. The Administrator stated the call light system logs did not specify what rooms or hallways were tested to assure the call light system was functioning in the residents' rooms, above the residents' doorways, and at the call light station, to assure the residents had a functional device in their possession. 2. Resident #43 was readmitted on 6/6/18 with diagnoses including spina bifida, contracted knees, and blindness. An admission MDS assessment dated 6/13/18, documented Resident #43 required extensive assistance with transfers, bed mobility, dressing, eating, toileting, and personal hygiene. A care plan updated 7/7/18, documented Resident #43 was totally dependent on staff for all ADL needs and staff were to encourage Resident #43 to use his call light. On 7/12/18 at 10:47 AM, Resident #43 demonstrated he was unable to turn on the call light, four consecutive times. Each time the call button was pushed, the resident stated he thought it was on, but the light on the wall was observed to have been off. On 7/12/18 at 10:53 AM, Resident #43 stated he had to wait a long time for anyone to answer his call light. He stated he had to call out for assistance daily. On 7/12/18 at 10:57 AM, the surveyor attempted three times to turn on the call light with no result.	F 919	(licensed administrator). The Maintenance Director is educated by the CEO to test resident room call system validating the call light is present and functional once a month, that outages are repaired immediately, or an alternate call system is implemented, and that the documentation reflects which rooms were tested. The system is amended to include monthly audit tool which identifies which rooms/call lights were tested. In addition, department manager rounds include location and testing of call lights for access and function. Monitor The Chief Executive Officer (licensed administrator) and/or designee will audit call light cord availability and function for 5 rooms weekly for 4 weeks, then 2 rooms weekly for 8 weeks. Starting the week of September 5, 2018, the review will be documented on the QAPI audit tool. Any concerns will be addressed immediately and discussed with the QAPI committee. The QAPI committee may adjust the frequency of the monitoring after 12 weeks, as it deems appropriate.	

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	135051		**07/13/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANYON WEST OF CASCADIA	**2814 SOUTH INDIANA AVENUE** **CALDWELL, ID 83605**

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F 919	Continued From page 109 On the fourth attempt, the call light on the wall turned on. On 7/12/18 at 10:59 AM, CNA #9 entered the room. She stated she had not realized Resident #43's call light was not working. On 7/12/18 at 11:17 AM, LPN #1 stated Resident #43 could use his call light. After the surveyor explained the attempts to turn on the call light had failed, LPN #1 stated she would see about changing the call light. On 7/12/18 at 3:35 PM, the DNS stated she expected the staff to change a nonfunctioning call light when it was noticed. She stated the person that noticed the call light should be the one to change it out. On 7/12/18 at 3:50 PM, the DNS stated she had changed the call light, and it was functioning properly.	F 919		

IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
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January 11, 2019

John Schulkins, Administrator
Canyon West of Cascadia
2814 South Indiana Avenue
Caldwell, ID 83605-5925

Provider #: 135051

Dear Mr. Schulkins:

On **July 13, 2018**, an unannounced on-site complaint survey was conducted at Canyon West of Cascadia. The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted on July 9, 2018 through July 13, 2018.

During the investigation, observations and resident, family representatives and staff interviews were conducted. Several residents attended the Resident Council meeting with the surveyors.

The identified resident's closed record including his hospital record, and the records of six other residents were reviewed.

The Infection Control Log from October 2017 through December 2017 was reviewed.

The Grievance Files were reviewed.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007674

ALLEGATION #1:

Residents were required to place feces in plastic bags for inspection, the bags of feces were placed inside the garbage cans and not taken care of properly. The resident recently had 2 toes amputated related to diabetes, treated for MRSA. The bags of feces are "dumped" into a red container kept at the

end of the bed. The red container is emptied every 2 to 3 days. Gowns are also available but the facility does not "make" them wear the gowns.

FINDINGS #1:

The Resident was admitted to the facility with multiple diagnoses, including surgery on his right foot complicated by MRSA (bacterial infection caused by Methicillin Resistant Staphylococcus Aureus).

On 7/13/18, The ICN (Infection Control Nurse) said after providing pericare to a resident the CNAs (Certified Nursing Assistants) should place the soiled adult incontinence briefs in a plastic bag and be taken out of the room.

Several CNAs were interviewed and said they took the soiled adult incontinence briefs out of the resident's room.

The ICN said PPE (Personal Protective Equipment) were placed at residents' doors who were on isolation precaution and would be available for staff and resident's visitors to use before entering the room. Two CNAs said they would wear PPE before entering a resident's room in isolation precaution.

Based on the investigative findings it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The urine and feces smell was always there, morning and night. The Resident's representative talked to a staff member and was told she could not bring in Febreze deodorizer spray.

FINDINGS #2:

The Administrator said the facility did not allow the use of any aerosol for safety reasons.

During the survey week, surveyors were into different hallways making observation, smells of urine or feces did not last for a long time.

The Grievance file was reviewed and no concerns regarding the odor in the facility were identified.

Residents in the group interview voiced no concerns regarding odor in the facility.

Based on investigative finding it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The Resident had diabetes, and complained about being hungry. They feed him very little and he has to ask for food. They do not offer/provide a snack at bedtime, except sometimes staff give him a peanut butter sandwich "out of the goodness of their hearts."

FINDINGS #3:

On August 12, 2018 at 3:41 PM, a CNA was observed pushing a snack cart. The CNA said snacks were distributed twice a day. The CNA said snacks were also available for residents at night time. Review of the Resident's meal intake record documented he was eating 76-100 % of his meals most of the time, and 25 out of 30 opportunities, the resident ate 51-75% of his snacks. Eight residents attended the Resident Council meeting with the surveyor and no one expressed concern about food or snacks.

Based on investigative findings it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,

Belinda Day, RN, Supervisor
Long Term Care Program

BD/lj

IDAHO DEPARTMENT OF
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BRAD LITTLE – Governor
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LICENSING & CERTIFICATION
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February 25, 2019

John Schulkins, Administrator
Canyon West of Cascadia
2814 South Indiana Avenue
Caldwell, ID 83605-5925

Provider #: 135051

Dear Mr. Schulkins:

On **July 13, 2018**, an unannounced on-site complaint survey was conducted at Canyon West of Cascadia. The complaint survey was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted from July 9, 2018 to July 13, 2018.

Staff response to call lights were observed throughout the survey. Facility staff were observed providing care, interacting with residents, and responding to residents' needs and requests promptly. The facility's grievance file and maintenance logs from May 2017 to July 2018 were reviewed. The facility's incident and accident reports from July 2017 to July 2018 were reviewed.

Several residents were interviewed regarding quality of care and quality of life concerns. Several nurses, CNAs, and management staff were interviewed regarding quality of care and quality of life concerns.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007633

ALLEGATION #1:

Resident had an injury of unknown origin.

FINDINGS #1:

Five residents' records, including the identified resident, were reviewed. No concerns of injury of unknown origin were identified.

Five residents were interviewed and no concerns were identified for injury of unknown origin. Several nurses and CNAs were interviewed. They said they would report bruises on a resident to the charge nurse and fill out an incident report for investigation to rule out abuse. The Director of Nursing was interviewed and she said if bruises were reported on a resident, an incident report would be filled out and an investigation started. After determining the cause of the injury, the Director of Nursing said she would report the findings to the State.

Based on the investigative findings, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The facility had ants in rooms.

FINDINGS #2:

During the week of survey no ants were identified in the facility, including residents rooms.

The grievance files from July 2017 to July 2018 were reviewed and the facility identified a concern with ants. The maintenance log from May 2017 to July 2018 were reviewed and the facility identified a concern. The facility had the pest control company out to spray rooms and surrounding areas.

The Administrator was interviewed and stated the facility identified concerns with ants in three rooms and notified the pest control company and the problem was resolved.

Based on the investigative findings, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

Staff do not respond to residents' call lights.

FINDINGS #3:

Duing the week of the survey, staff and residents were observed, maintenance logs were reviewed and staff and resident interviews were conducted.

A resident was observed in his room without a call light. The resident stated he had not had a call light for an extended period of time.

The Administrator provided maintenance call system checks from November 2017 - May 2018. The Administrator stated the call light system logs did not specify what rooms or hallways were tested to assure the call light system was functioning in the residents' rooms, above the residents' doorways, and at the call light station, and to assure residents had a functional device in their possession.

Based on investigative findings, the allegation was substantiated and the facility was cited at F558 and F919. Please refer to federal 2567 report for details.

CONCLUSIONS:

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

ALLEGATION #4:

Residents are not receiving assistance with meals, equipment, and personal care.

FINDINGS #4:

Facility staff were observed providing care and assistance with several residents throughout the survey and did so appropriately.

Five resident's were interviewed regarding staff providing care and assistance and voiced no concerns.

Several CNAs, nurses, and the Director of Nursing were interviewed regarding staff providing care with equipment, personal care, and meal assistance and no concerns were identified.

Based on the investigative findings, 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 any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,

Laura Thompson, RN, Supervisor
Long Term Care Program

LT/lj

IDAHO DEPARTMENT OF
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May 16, 2019

John Schulkins, Administrator
Canyon West of Cascadia
2814 South Indiana Avenue
Caldwell, ID 83605-5925

Provider #: 135051

Dear Mr. Schulkins:

On **July 9, 2018** through **July 13, 2018**, an unannounced on-site complaint survey was conducted at Canyon West of Cascadia. The complaint investigation occurred in conjunction with a recertification survey. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007463

ALLEGATION #1:

Residents were not provided with adequate bathing and accommodation of need.

FINDINGS #1:

Observations were conducted throughout the facility, staff were interviewed, residents were interviewed, and family members were interviewed. Thirteen resident records were reviewed, five of which were closed records.

Eight resident records were reviewed for quality of care and assistance with Activities of Daily Living (ADL), specifically bathing and hygiene assistance, as well as appropriate nail care. Six of the eight resident records documented showers were not given consistently and oral hygiene was not consistently provided.
The residents were observed in their rooms, in the common areas, and dining rooms and

appeared ungroomed, smelled of odors, and had unclean teeth. A resident was observed with a fish like odor coming from their room and another resident was observed with hair which appeared unkempt and unwashed.

Several residents were observed for nail care and no concerns were identified.

A resident stated the facility had not provided a toothbrush or toothpaste, since their admission to the facility. The resident stated if they had the supplies they would brush their teeth.

Staff interviews were conducted regarding showers and ADL care. Eight CNAs and two Licensed Practical Nurses (LPNs), and the Director of Nursing Services were interviewed. The staff stated residents were not consistently provided their showers twice weekly due to staffing issues.

Based on the investigative findings, the allegation was substantiated and deficiencies were cited at F677 and F725 as it related to the failure of the facility to ensure residents received adequate assistance with ADLs.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2 :

The facility did not send appropriate documentation or supplies with a resident to an appointment.

FINDINGS #2 :

During the investigation three resident records were reviewed for transfer and discharge requirements. Staff were also interviewed for the transfer and discharge requirements.

One resident was admitted to the facility in April 2018, with diagnoses including multiple neck fractures, stroke, legal blindness, and multiple contractures.

Review of one resident's record documented he/she was transferred from the facility to the hospital in June 2018 with complaints of nausea, vomiting, and abdominal pain.

A progress note dated 6/2/18, documented the resident was sent to the ER via ambulance. The progress note did not document if written documents were given to the ambulance personnel or a written, verbal, or faxed report was provided to the hospital staff.
The Director of Nursing Services stated the facility did not have a discharge/transfer form. She

stated the facility would have included a face sheet, medication list, physician orders and advanced directive with a resident for a transfer to another agency. She stated they did not have documentation of what documents were sent to the hospital with the resident on 6/2/18. The DNS stated they did not document what supplies were sent with residents during appointments. The DNS stated if a resident needed assistance from staff the staff would stay with them during their appointments and have the supplies needed for residents' needs.

The Medical Records Coordinator stated the facility did not keep copies of transfer documents in the residents' records. She stated the face sheet, diagnoses list, vital sign history, medication list, advanced directive, and physician's orders were printed and sent with the resident when transferred to a physician's office or hospital.

Based on the investigative findings, the allegation was substantiated and a deficiency was cited at F622 as it related to the failure of the facility to ensure residents' medical information was provided to the transferring agency or provider to meet the resident's needs.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

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 any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,

Laura Thompson, RN, Supervisor
Long Term Care Program

LT/lj

IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

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May 17, 2019

John Schulkins, Administrator
Canyon West of Cascadia
2814 South Indiana Avenue
Caldwell, ID 83605-5925

Provider #: 135051

Dear Mr. Schulkins:

On July 9, 2018 through July 13, 2018, an unannounced onsite complaint and recertification investigation was conducted at Canyon West of Cascadia. Observations were conducted, interviews were conducted with residents, family members and staff members. Thirteen resident records were reviewed including five closed records.

The complaint allegations or entity-reported incidents, findings and conclusions are as follows:

Complaint #ID00007815

ALLEGATION #1

Residents were not assisted with Activities of Daily Living as needed.

FINDINGS #1:

Eight resident records were reviewed for quality of care and assistance with Activities of Daily Living (ADL), specifically bathing and hygiene assistance, as well as appropriate nail care. Six of the eight records documented showers and/or oral hygiene were not consistently provided.

Residents were observed in their rooms, in the common areas, and dining rooms and some of the residentes appeared ungroomed, smelled of odors, and had unclean teeth. A resident was observed with a fish like odor noted coming from their room and another resident was observed with hair which appeared unkempt and unwashed.

One resident stated the facility had not provided a toothbrush or toothpaste, since their admission and if they had the supplies they would brush their teeth.

One resident's record documented in the care plan assistance was needed with ADLs such as transfers, ambulation with a wheelchair, bed mobility, and toilet use by one to two staff members daily. The record documented the resident's health gradually declined and they required assistance from staff until their discharge in February 2018.

Staff were interviewed regarding showers and ADL care. The interviews included eight CNAs and two Licensed Practical Nurses (LPN), and the Director of Nursing Services (DNS). The staff stated residents were not consistently provided their showers twice weekly due to low staffing issues. Staff interviewed recalled the resident discussed above and stated showers where not always completed for that resident.

Based on the investigative findings the allegation was substantiated and deficiencies were cited at F677 and F725 related to the failure of the facility to ensure residents received adequate assistance with ADLs.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

The facility obtained guardianship for a resident without his family's knowledge or consent and their life support was stopped by the facility while the resident was in a hospital.

FINDINGS #2

During the investigation fifteen residents were observed and twenty resident records, which included a closed record, were reviewed for resident rights. Interviews were conducted with residents and family members, and staff members were interviewed and observed regarding resident rights. Facility abuse allegations, grievances, and Resident Council minutes were reviewed.

The facility's abuse allegations, grievances, and Resident Council minutes were reviewed and did not include documentation of concerns with resident rights related to guardianship or life support.

Resident records were reviewed for signs of abuse and allegations of abuse, including a resident admitted to the facility in July 2016. The resident's record documented a family member frequently signed out money from the resident's account 1-2 times a month. Two financial statements documented a family member signed out the money for the resident. Two nurses stated they observed a family member sitting next to the resident while he signed out money and handed the money to the family member after they asked for the money. The progress notes documented the resident became upset and did not remember the money was taken, and then was frustrated he could not utilize his money a few days after the withdrawal. The notes documented he had memory issues.

The facility identified a family member was financially exploiting the resident, and multiple Social Services progress notes documented, and interviews stated, the facility requested and obtained a State appointed guardian to protect the resident from financial exploitation. There was evidence the facility acted appropriately when notifying the State of the need for the guardianship. The guardianship paperwork documented a court appointed guardian, who was not associated with the facility, was put into place for the resident. The facility, and its staff, did not discontinue the resident's life support because they were not the resident's guardian.

Several residents and two family members said staff were not abusive and they had no concerns regarding staff retaliation if they raised a concern or a complaint. Multiple staff said if they suspected or witnessed any form of abuse or retaliation, they reported it immediately.

Based on investigative findings the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3

A resident's Hemoglobin A1C test was not completed by the facility as ordered by the physician.

FINDINGS #3:

During the investigation fifteen residents were observed and twenty resident records, which included a closed record, were reviewed for diabetic management. Iinterviews were conducted with residents and family members. Staff were interviewed and observed providing diabetic care.

Grievances and Resident Council minutes were reviewed.

The facility's grievances and Resident Council minutes were reviewed and did not include documentation of concerns with resident rights.

The resident records were reviewed for diabetic management, including a resident admitted to the facility in July 2016. The resident's record documented a physician's order for a Hemoglobin A1C test be completed. A physician's progress note on 1/25/18 documented the results of the completed Hemoglobin A1C test.

Several residents said the facility frequently assessed their Hemoglobin A1C levels and they had no concerns with their diabetic management. Staff said the facility routinely assessed residents A1C levels according to physician orders.

Based on investigative findings the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

A resident was not provided candy by the nursing staff when his/her family requested.

FINDINGS #4:

During the investigation fifteen residents were observed and twenty resident records, which included a closed record, were reviewed for dietary concerns. Multiple interviews were conducted with residents and family members. Staff were interviewed and observed regarding dietary concerns. Facility grievances and Resident Council minutes were reviewed.

One resident was readmitted to the facility in July 2016, with diagnoses which included dysphagia or difficulty with swallowing and diabetes.

The resident's record documented the physician ordered a diabetic, modified textured diet, to include pureed foods. The record documented the resident had a fluid restriction as well. The progress notes documented and interviews with multiple staff members stated the resident's family provided candy inconsistent with the resident's physician prescribed diet order and staff had to prevent the resident from eating the candy and choking.

Several residents said staff provided foods consistent with their orders.

Based on the investigative findings the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

Residents' belongings were not returned to the family after a resident discharged to the hospital.

FINDINGS #5:

During the investigation fifteen residents were observed and twenty resident records, which included a closed record, were reviewed. Interviews were conducted with residents and family members. Staff were interviewed and observed. Facility grievances and Resident Council minutes were reviewed.

The facility's grievances, and Resident Council minutes were reviewed and did not include documentation of concerns regarding missing items.

A resident, admitted to the facility in July 2016, did not include documentation in the record of missing items which were not found. The nurse progress notes did not document misplaced items not found. A progress note documented a family member asked the facility about a key the resident wore around their neck and the resident did not have a key on his inventory list.

Several residents and two family members said staff were good about finding missing items and replacing them if they could not be located. Three CNAs and two nurses who had worked with the above resident, said they did not recall him having missing items.

Based on investigative findings 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 any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,

Laura Thompson, RN, Supervisor
Long Term Care Program

LT/lj

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August 5, 2019

John Schulkins, Administrator
Canyon West of Cascadia
2814 South Indiana Avenue
Caldwell, ID 83605-5925

Provider #: 135051

Dear Mr. Schulkins:

On **July 9, 2018** through **July 13, 2018**, an unannounced on-site complaint survey was conducted at Canyon West of Cascadia. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007772

ALLEGATION #1:

A resident had multiple falls during a five day respite at the facility.

FINDINGS #1:

During the survey fifteen resident records were reviewed, observations were conducted, facility incident and accident reports were reviewed, and staff were interviewed.

Observations were conducted during the survey for quality of care and quality of life concerns. Three residents were observed with fall precautions in place.

Three residents' records were reviewed. One resident was admitted in February 2018 for a five day respite stay. The resident was admitted with hospice services and had dementia. An incident and accident report documented the resident had an unwitnessed fall from the bed and sustained no injuries.

The resident's record documented the facility provided additional fall precaution interventions and assessments throughout the five days the resident was at the facility.

The DNS stated when the resident fell out of bed with no injuries, new interventions were implemented to reduce further falls. A fall mat was placed next to the bed and the staff were aware of the care needs the resident required. The DNS stated the resident did not have another fall for the rest of the five day stay.

Based on the investigative findings, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The facility's staff did not notify resident's emergency contact after a fall.

FINDINGS #2:

Three residents' records were reviewed for emergency contact person notification after a fall. Two of three residents' emergency contact were notified of the resident's fall.

One of the three resident's record documented the person who was designated the resident's Power of Attorney (POA) was going to be out of town. The record listed another person for an emergency. An incident and accident report documented emergency contact was notified of the resident's fall.

The admission coordinator stated when the resident was admitted to the facility for the five day respite, the POA stated to list another person as an emergency contact, not the POA.

Based on the investigative findings, the allegation was not able to be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

Residents are hallucinating and acting as if they were on narcotics.

FINDINGS #3:

Five residents' records were reviewed for unnecessary medications and side effects. Four of the five residents' records documented the medications were appropriate for the residents' needs. The pharmacist, physician, and the facility were assessing and monitoring for side effects and appropriateness of the medications.

One of the five residents' records, admitted February 2018 for a five day respite, documented medications the resident received prior to admission to the facility, did not include narcotics. The resident's record documented the resident had dementia without behavioral disturbances.

Based on the investigative findings, the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,

Belinda Day, RN, Supervisor
Long Term Care Program

BD/lj