



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE- Governor
DAVE JEPPESEN- Director

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

March 6, 2020

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

Provider #: 135051

Dear Mr. Schulkins:

On **February 21, 2020**, 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.

John Schulkins, Administrator
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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 **March 16, 2020**. Failure to submit an acceptable PoC by **March 16, 2020**, may result in the imposition of civil monetary penalties by **April 8, 2020**.

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*.

We are recommending that Centers for Medicare & Medicaid Services (CMS) Region X impose the following remedy(ies):

- Civil Money Penalty
- Denial of Payment for new admission effective May 21, 2020

John Schulkins, Administrator
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We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **August 21, 2020**, 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 Laura Thompson, RN, or Belinda Day, RN, Co-Supervisors, LTC, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

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)

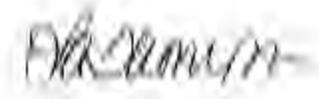
[2001-10 Long Term Care Informal Dispute Resolution Process](#)
[2001-10 IDR Request Form](#)

This request must be received by **March 16, 2020**. If your request for informal dispute resolution is received after **March 16, 2020**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

John Schulkins, Administrator
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Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Belinda Day, RN, or Laura Thompson, RN, Supervisors, Long Term Care Program at (208) 334-6626, option #2.

Sincerely,

A handwritten signature in black ink, appearing to read "Laura Thompson".

Laura Thompson, RN, Supervisor
Long Term Care Program

lt/lj
Enclosures

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

PRINTED: 03/23/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/21/2020
NAME OF PROVIDER OR SUPPLIER CANYON WEST OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification and complaint survey conducted from February 18, 2020 through February 21, 2020. The surveyors conducting the survey were: Cecilia Stockdill, RN, Team Coordinator Sallie Schwartzkopft, LCSW Ann Monhollen, RN Karen Gray, RD Survey Abbreviations: DON = Director of Nursing IV = intravenous LPN = Licensed Practical Nurse MDS = Minimum Data Set mg = milligrams NP = Nurse Practitioner RN = Registered Nurse SDC = Staff Development Coordinator	F 000			
F 580 SS=G	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or	F 580		4/8/20	

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

TITLE

(X6) DATE

Electronically Signed

03/16/2020

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 580	<p>Continued From page 1 clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).</p> <p>§483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and</p>	F 580	This Plan of Correction is prepared and		

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F 580	<p>Continued From page 2</p> <p>resident and staff interview, it was determined the facility failed to ensure the physician was notified of a significant change in a resident's condition. This was true for 1 of 1 resident (Resident #19) reviewed for change of condition. This failed practice resulted in harm to Resident #19 when he experienced a change in condition that resulted in hospitalization due to sepsis (a potentially life-threatening condition caused by the body's response to an infection), community acquired pneumonia, urinary tract infection, and Influenza A. Findings include:</p> <p>The facility's policy for Resident Change of Condition, dated 11/28/17, documented the following:</p> <ul style="list-style-type: none"> * "Upon recognition of a potentially life-threatening condition or significant change in status, the nurse should communicate with other health care providers to meet the needs of the resident." * The physician was informed at the time of the event, as soon as possible. * Notification occurred immediately if any symptom was sudden in onset, a marked change from the usual signs and symptoms, and unrelieved by prescribed measures. * For non-immediate notification, the physician was informed of the event during office hours and generally no later than the next regular business day. If a non-immediate event occurred on a weekend or holiday, good nursing judgment determined if the notification could wait until the next business day or if it should occur during the weekend or holiday. * The facility informed the resident, consulted with the physician, and notified the resident's 	F 580	<p>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, findings, facts, and conclusions that form the basis for the deficiency.</p> <p>Resident Specific: The ID team reviewed resident #19 and ensured the physician has been notified of he significant change in his blood pressure and health status. Adjustments have been made as indicated.</p> <p>Other Residents: The ID team reviewed other residents for appropriate physician notification when there was a significant change in their blood pressures and health status. Adjustments have been made as indicated.</p> <p>Facility Systems: Staff are educated to notify the physician when there is a significant change in blood pressure and health status. Re-education was provided by the Chief Nursing Officer to include but not limited to, contacting the physician when blood pressure and health status significantly change. The system is amended to include review significant change in blood</p>		

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F 580	<p>Continued From page 3</p> <p>representative when there was a significant change in the resident's physical, mental, or psychosocial status.</p> <p>This policy was not followed.</p> <p>Resident #19 was admitted to the facility on 6/6/18 and readmitted to the facility on 1/16/20, with multiple diagnoses including spina bifida (a birth defect that occurs when the spine and spinal cord don't form properly), hemiplegia and hemiparesis (weakness and paralysis) affecting the right side following a stroke, neuropathic bladder (a bladder that does not empty or store urine properly due to a neurological condition or spinal cord injury), and history of traumatic brain injury.</p> <p>A progress note by the Medical Director, dated 1/2/20, documented he saw Resident #19 due to increased urinary sediment, which necessitated staff changing his catheter every 5 or 6 days. The progress note documented Resident #19's skin was warm and dry. The Medical Director recommended encouraging fluids and changing Resident #19's catheter as needed due to obstruction.</p> <p>A Progress Note by the NP, dated 1/7/20, documented he saw Resident #19 due to pain all over his body that felt like arthritis pain. The NP documented the pain was well controlled with Tylenol, and there was no fever or chills. Resident #19's blood pressure was 152/77, temperature was 97 degrees Fahrenheit (F), and pulse was 63. The note stated his skin was warm and dry, and his lungs were clear. The treatment plan was to continue scheduled Tylenol 325 mg 2</p>	F 580	<p>pressure and health status by the CNO or designee on a regular basis and at least during the regular clinical meeting.</p> <p>Monitor: The Chief Nursing Officer and/or designee will audit 5 residents for physician notification weekly for 4 weeks, then 2 residents weekly for 8 weeks. Starting the week of April 8, 2020 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.</p>		

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F 580	<p>Continued From page 4</p> <p>tablets three times a day as well as Tylenol 2 tablets three times daily as needed and follow up with urology as needed.</p> <p>A progress note, dated 1/9/20 at 8:30 PM, documented Resident #19 stated "I'm burning up." The note documented his blood pressure was 156/77, a heart rate of 88, and a temperature of 99.0 F.</p> <p>A progress note, dated 1/10/20 at 3:35 AM, documented Resident #19 had a distended (swollen) abdomen with less active bowel sounds. The note documented Resident #19 told the nurse he had not had a bowel movement in two weeks. The note also documented Resident #19's had a blood pressure of 82/54, a heart rate of 91, and a temperature of 99.0 F. The nurse documented Resident #19 was medicated for his temperature and given a Dulcolax suppository (laxative). There was no documentation Resident #19's physician was notified of his low blood pressure and he had a distended abdomen with no bowel movement in two weeks.</p> <p>According to the Mayo Clinic website, accessed 3/4/20, a sudden fall in blood pressure can be dangerous. A change of just 20 mm Hg (millimeters of mercury), such as a drop from 110 systolic (top number) to 90 mm Hg systolic, can cause dizziness and fainting when the brain fails to receive an adequate supply of blood. The Mayo Clinic website stated big plunges, such as those caused by uncontrolled bleeding, severe infections or allergic reactions, can be life-threatening.</p> <p>The Fundamentals of Nursing, eighth edition, by</p>	F 580			

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F 580	<p>Continued From page 5</p> <p>Potter and Perry (2013) stated hypotension when associated with paleness, skin mottling, clamminess, confusion, increased heart rate, or decreased urine output is considered life threatening and should be reported to a health care provider immediately.</p> <p>Resident #19's systolic blood pressure had dropped 74 mmHg in eight hours.</p> <p>A progress note, dated 1/11/20 at 9:16 AM, documented Resident #19 complained of "extreme pain," and he was perspiring profusely. His blood pressure was 88/58, the heart rate was 118, and temperature was 101 F. Resident #19 was sent to the emergency room.</p> <p>A history and physical from the hospital, dated 1/11/20, stated Resident #19 presented to the Emergency Room with rapid breathing and hypotension. Resident #19 was admitted to the hospital with severe sepsis, community acquired pneumonia, urinary tract infection, and Influenza A.</p> <p>On 2/20/20 at 10:03 AM, the DON said she spoke to the NP, and he said although Resident #19 met the criteria for sepsis, he did not have sepsis because his white blood cell count was normal. The DON said she did not know if the physician was notified when Resident #19 demonstrated signs of fever and becoming ill.</p> <p>On 2/20/20 at 12:01 PM, the Medical Director said Resident #19 was chronically sick and became ill rapidly when he had to go to the hospital in January 2020. The Medical Director said the facility's nurses monitored residents' vital</p>	F 580			

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F 580	Continued From page 6 signs and notified him if they were abnormal. The Medical Director said Resident #19 was feeling sick, and the nurses would not necessarily notify him of "things like that if the vital signs were okay." The Medical Director said Resident #19 could become ill very quickly, and he would have to read the hospital report to see if he had a urinary tract infection. The Medical Director said if one vital sign was abnormal he would not be concerned. The Medical Director said Resident #19 was at risk for infection due to the bacteria in the environment and the fact he had a catheter, a feeding tube, and immobility. On 2/21/20 at 10:19 AM, the DON said "something should have been done" related to Resident #19's blood pressure on 1/10/20 at 3:35 AM. Resident #19's physician was not notified when he had a significant change in his blood pressure and health status.	F 580			
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when	F 582		4/8/20	

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F 582	<p>Continued From page 7</p> <p>changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.</p> <p>§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.</p> <p>(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.</p> <p>(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.</p> <p>(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.</p> <p>(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.</p> <p>(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 582			

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F 582	<p>Continued From page 8</p> <p>by:</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure residents were provided with an Advance Beneficiary Notice (ABN) at the termination of their Medicare Part A benefits. This was true for 2 of 3 residents (#16 and #254) reviewed for an ABN. This failure created the potential for residents to experience financial and psychological distress when they were not informed of their potential liability for payment. Findings include:</p> <p>a. Resident #16 was admitted to the facility initially on 1/31/17, and readmitted on 8/21/19, with multiple diagnoses including thyroid disorder (regulation of hormones), depression, muscle weakness, and peripheral neuropathy (diseased nerves causing weakness).</p> <p>Resident #16's MDS assessment, dated 9/28/19, documented his most recent Medicare stay ended on 9/28/19. Resident #16 remained in the facility. His record did not include an ABN.</p> <p>b. Resident #254 was admitted to the facility on 7/25/19, with multiple diagnoses including heart failure, septicemia (a bacterial infection which has spread into the blood stream), urinary tract infection, depression, respiratory failure, muscle weakness, morbid (severe) obesity, and dependence on supplemental oxygen.</p> <p>Resident #254's MDS assessment, dated 9/13/19, documented her most recent Medicare stay ended on 9/13/19. Resident #254 remained in the facility. Her record did not include an ABN.</p>	F 582	<p>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, findings, facts, and conclusions that form the basis for the deficiency.</p> <p>Resident Specific: Resident #16 has been provided with an ABN. Resident #254 no longer resides at the facility.</p> <p>Other Residents: Other residents were reviewed for need for ABN. ABN was provided as indicated.</p> <p>Facility Systems: The MDS staff is educated to provide the ABN as indicated. Re-education was provided by the Chief Executive Officer to include but not limited to ensuring that the ABN letter is provided as required. Any resident qualifying for ABN under Medicare guidelines will receive a letter. All changes in payer status will be reported in the daily meeting so that ABN can be issued as required.</p> <p>Monitor: The Chief Executive Officer and/or</p>		

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

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F 582	Continued From page 9 On 2/20/19 at 2:00 PM, the MDS Nurse said she did not have documentation Resident #254 received the ABN. The MDS Nurse said Resident #16's and Resident #254's records did not include the ABN. Resident #16 and Resident #254 did not have documentation in their records they received an ABN.	F 582	designee will audit all ABN letter distribution weekly for 3 weeks, then 2 ABN letter distributions (if occurred) weekly for 8 weeks. Starting the week of April 8, 2020 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 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	F 656		4/8/20	

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F 656	<p>Continued From page 10 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)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(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.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure a resident's care plan included their code status. This was true for 1 of 14 residents (Resident #19) whose care plans were reviewed. This failure created the potential for harm should residents receive inappropriate or inadequate care due to lack of information on the care plan. Findings include:</p> <p>Resident #19 was admitted to the facility on 6/6/18 and readmitted to the facility on 1/16/20, with multiple diagnoses including spina bifida (a birth defect that occurs when the spine and spinal cord don't form properly), hemiplegia and hemiparesis (weakness and paralysis) affecting the right side following a stroke, neuropathic bladder (a bladder that does not empty or store urine properly due to a neurological condition or spinal cord injury), and history of traumatic brain</p>	F 656	<p>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, findings, facts, and conclusions that form the basis for the deficiency.</p> <p>Resident Specific: The clinical management team reviewed resident #19 for identification of code status in the care plan. The resident care plan has been updated to include code status.</p>		

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F 656	Continued From page 11 injury. Resident #19's discharge MDS assessment, dated 1/11/20, documented he had short-term memory problems. Resident #19's Living Will and Durable Power of Attorney for Health Care, dated 8/9/18, documented he wished to have all medical treatment, care, and procedures needed to restore health and sustain life. Resident #19's code status was not documented in his care plan. On 2/19/20 at 4:11 PM, the Licensed Social Worker (LSW) said she was the one who usually entered the residents' code status on their care plan, and she did not know why it was not on Resident #19's care plan. The facility did not document Resident #19's code status on his care plan.	F 656	Other Residents: The clinical management team reviewed resident #19 for identification of code status on the resident care plan. The care plans have been updated as indicated. Facility Systems: Social Services and 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 code status on the care plan when a new MDS is completed. Validation of the code status being on the care plan occurs as comprehensive care plans are reviewed. Monitor: The Chief Nursing Officer and/or designee will audit 5 resident records for validation that the code status is included on the care plan weekly for 4 weeks, then 2 resident records for 8 weeks. Starting the week of April 8, 2020 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	F 684		4/8/20	

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F 684	<p>Continued From page 12</p> <p>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:</p> <p>Based on record review, policy review, and resident and staff interview, it was determined the facility failed to identify a skin abscess on a resident. This was true for 1 of 3 residents (Resident #19) reviewed for infections. This resulted in harm to Resident #19 when he developed the skin abscess and was sent to the hospital and the abscess likely contributed to his diagnosis of severe sepsis (a potentially life-threatening condition caused by the body's response to an infection). Findings include:</p> <p>The facility's policy for Prevention and Treatment of Pressure Ulcers and Other Skin Alterations, revised 7/13/18, documented residents had routine weekly skin checks to confirm there were no unidentified skin concerns. In addition, staff were to address potential new areas of concern. This policy was not followed.</p> <p>Resident #19 was admitted to the facility on 6/6/18 and readmitted to the facility on 1/16/20, with multiple diagnoses including spina bifida (a birth defect that occurs when the spine and spinal cord don't form properly), hemiplegia and hemiparesis (weakness and paralysis) affecting the right side following a stroke, neuropathic bladder (a bladder that does not empty or store urine properly due to a neurological condition or spinal cord injury, and history of traumatic brain injury.</p>	F 684	<p>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, findings, facts, and conclusions that form the basis for the deficiency.</p> <p>Resident Specific: The scrotal abscess for resident #19 was identified at the hospital by the urologist upon examination.</p> <p>Other Residents: The clinical management team reviewed other residents for risk of development of skin abscesses that may lead to severe sepsis. Adjustments were made as indicated.</p> <p>Facility Systems: Licensed nurses are educated to review residents for signs/symptoms of symptoms related to skin abscesses that may lead to severe sepsis. The system is</p>		

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F 684	<p>Continued From page 13</p> <p>Resident #19's care plan directed staff to perform daily skin inspection during cares, notify the nurse of impaired skin integrity, the licensed nurse was to perform weekly skin assessments, and staff were to monitor for increased urethral erosion from the indwelling catheter.</p> <p>Resident #19's weekly skin checks, dated 11/14/19 at 10:04 AM through 1/2/20 at 6:26 AM, documented he had a urethral erosion (a wound often caused by the long term use of indwelling catheters) on his penis. The skin checks did not document an abscess on his scrotum.</p> <p>A progress note by the Medical Director, dated 1/2/20, documented he saw Resident #19 due to increased urinary sediment, which necessitated staff changing his catheter every 5 or 6 days. The progress note documented Resident #19's skin was warm and dry. The Medical Director recommended encouraging fluids and changing Resident #19's catheter as needed due to obstruction.</p> <p>A progress note by the NP, dated 1/7/20, documented he saw Resident #19 due to pain all over his body that felt like arthritis pain. The pain was well controlled with Tylenol, and there was no fever or chills. The NP stated Resident #19's skin was warm and dry.</p> <p>A discharge MDS assessment, dated 1/11/20, documented Resident #19 had an unplanned discharge to the hospital. The assessment documented he had an indwelling catheter and there was no documentation he had skin problems.</p>	F 684	<p>amended to review abnormalities found during skin checks and subsequent clinical meeting review.</p> <p>Monitor: The Chief Nursing Officer and/or designee will audit 4 residents to validate proper documentation related to skin checks and other signs of scrotal abscesses weekly for 4 weeks, then 2 residents weekly for 8 weeks. Residents will be reviewed for skin, pain, and temperature and appropriate follow up as indicated. Starting the week of April 8, 2020 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.</p>		

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F 684	Continued From page 14 A History and Physical (H&P) from the hospitalist, dated 1/11/20 at 1:59 PM, documented Resident #19 had an abscess (a painful collection of pus, usually caused by a bacterial infection, just under the skin) in the scrotum/perineal area. The H&P documented an abscess was noted in the scrotum when his catheter was changed, and a urologist opened the abscess and placed packing (a type of dressing) into the open wound. A Urology progress note, dated 1/13/20 at 4:43 PM, documented Resident #19 had a left scrotal abscess, chronic urinary retention, a urethral erosion, and sepsis (a potentially life-threatening condition caused by the body's response to an infection) due to pneumonia and urinary source. The progress note documented the left scrotal abscess was also likely contributing to the sepsis. On 2/20/20 at 12:01 PM, the Medical Director said Resident #19 had a groin mass "or something" and was being followed by urology for that. The Medical Director said Resident #19 was at risk for infection due to the bacteria in the environment and the fact he had a catheter, a feeding tube, and his immobility. On 2/20/20 at 9:19 AM, Resident #19 said he was very ill and had to go to the hospital in January, but he did not remember how he became ill. Resident #19 said staff did not clean his catheter every day. On 2/20/20 at 10:03 AM, the DON said Resident #19's abscess was not visualized and detected by staff because it was in an area that was not	F 684			

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F 684	Continued From page 15 easily seen. On 2/20/20 at 4:14 PM, the DON said skin checks were done weekly, and Resident #19's abscess was not noticed until his catheter was replaced at the hospital. The facility did not identify Resident #19's scrotal abscess.	F 684			
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on policy review, record review, and staff interview, it was determined the facility failed to ensure residents were provided with the levels of supervision necessary to prevent falls. This was true for 1 of 2 residents (Resident #25) reviewed for falls. This failure resulted in harm to Resident #25 with a fracture to his left femur. Findings include: The facility's Accidents and Supervision to Prevent Accidents policy and procedure, dated 4/4/19, documented the facility provided an environment that was free from accident hazards over which the facility had control and provided supervision and assistive devices to each resident to prevent avoidable accidents. This	F 689	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, findings, facts, and conclusions that form the basis for the deficiency. Resident Specific: The ID team reviewed resident #25 for	4/8/20	

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F 689	<p>Continued From page 16 included systems and processes designed to:</p> <ul style="list-style-type: none"> * Identify hazards and risks. * Evaluate and analyze hazards and risks. * Implement interventions to reduce hazards and risks. * Monitor for effectiveness and modify approaches when necessary. <p>The policy also stated the facility was obligated to provide adequate supervision to prevent accidents, which was determined by assessing the appropriate level and number of staff required, the competency and training of the staff, and the frequency of supervision needed. This determination was based on the individual resident's assessed needs and identified hazards in the resident environment.</p> <p>Resident #25 was admitted to the facility initially on 5/21/19 and readmitted on 12/13/19, with multiple diagnoses including Alzheimer's disease, diabetes mellitus Type 2, cognitive social or emotional deficit following other cerebrovascular disease, and dementia with behavioral disturbance.</p> <p>Resident #25's MDS Assessment, dated 11/28/19, documented he was severely cognitively impaired and he required extensive assistance with two or more persons for bed mobility, toilet use, and transfers between bed, chair and standing. The assessment also documented Resident #25 required supervision with one-person physical assist when he walked between locations in his room. The Fall History section of the MDS assessment was not completed.</p>	F 689	<p>documentation of interventions related to his falls on the care plan, including appropriate supervision and assistance. Adjustments have been made as indicated.</p> <p>Other Residents: The ID team reviewed other residents for appropriate supervision and assistance being in place to protect them from injury. Adjustments have been made as indicated.</p> <p>Facility Systems: Licensed nurses are educated on ensuring appropriate supervision to protect the resident from injury and to minimize risk of falls. Re-education was provided by the Chief Nursing Officer to include but not be limited to appropriate supervision to protect the resident from injury and to minimize risk of falls. Preventive measures are initiated by the nurse who is providing care for the resident. Fall risks and resident history will be reviewed and monitored in the daily clinical meeting. Adjustments to the plan of care are made as indicated by the clinical team.</p> <p>Monitor: The Chief Nursing Officer and/or designee will audit 5 residents for supervision and assistance necessary weekly for 4 weeks, then 2 residents weekly for 8 weeks. Starting the week of April 8, 2020 the review will be documented on the QAPI audit tool. Any</p>		

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F 689	<p>Continued From page 17</p> <p>Resident #25's MAHC-10 Fall Risk Assessments, used to determine a person's risk for falls, dated 8/4/19, 8/12/19, 9/28/19, 10/7/19, 11/27/19, and 12/6/19, documented Resident #25 was at risk for falls. A score of 4 or more out of 10 was considered at risk for falls. Resident #25 received a score of 7 to 10 on the days of his falls.</p> <p>Resident #25's care plan documented he was at risk for falls related to confusion, diminished safety awareness, gait and balance problems, and history of falls and significant dementia. The care plan was initiated on 6/3/19. The interventions included the following:</p> <ul style="list-style-type: none"> * Wear non-skid footwear, initiated on 6/3/19 and revised on 8/3/19. * Staff need to anticipate his needs, initiated on 6/3/19 and revised on 8/3/19. * Resident #25 needs his door open, so staff can see him, initiated on 8/5/19 and revised on 12/2/19. * Encourage Resident #25 to use the grab bar near the bathroom to help balance himself, initiated on 12/2/19. <p>Resident #25's care plan documented he had an activities of daily living (ADL) self-care performance deficit related to dementia, impaired cognition related to advanced dementia, impaired balance, and history of fall with left hip fracture, initiated on 5/22/19 and revised on 12/16/20. Interventions included the following:</p> <ul style="list-style-type: none"> * Toilet use: he was not to be toileted. He had a catheter and was incontinent, initiated on 5/22/19 and revised on 9/18/19. * Transfers: He needed extensive assistance from staff, using a gait belt with transferring, 	F 689	<p>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.</p>		

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F 689	<p>Continued From page 18</p> <p>initiated on 5/22/19 and revised on 9/18/19.</p> <p>* Bed Mobility: He required extensive 2 staff participation to reposition and turn in bed, initiated on 5/22/19 and revised on 9/18/19.</p> <p>* Physical Therapy and Occupational Therapy were to provide evaluation and treatment per physician orders, initiated on 5/22/19.</p> <p>* He needed to eat all meals in the dining room, initiated on 8/5/19.</p> <p>Facility Incident and Accident reports for Resident #25 documented he fell 8 times from 8/4/19 to 12/6/19, with the last fall resulting in a major injury. Resident #25 had documented falls on 8/4/19, 8/11/19, 9/4/19, 9/28/19, 10/7/19, 10/11/19, and twice on 12/6/19.</p> <p>The reports documented the following:</p> <p>a. A Post Fall Investigation report documented Resident #25 had an unwitnessed fall without injury on 8/4/19 at 8:15 AM. Resident #25 was found alone and unattended in his room during meal time, laying on his back parallel and next to his bed, with his arms at his sides, his legs straight out, and with stockings on his feet. The report documented Resident #25 had a history of falls on 5/25/19, 6/1/19, and 7/30/19. The investigation documented Resident #25 had dementia, was impulsive, lacked safety awareness, and had an unsteady gait. The physician and family were notified of the fall.</p> <p>An Incident Conclusion and Performance Improvement Follow-Up report, dated 8/5/19, documented the Performance Improvement (PI) Recommendations post fall were to place Resident #25's bed in the low position, he was</p>	F 689			

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F 689	<p>Continued From page 19</p> <p>not to eat in his room, and he was to be out of his room when out of bed.</p> <p>Resident #25's care plan did not document his bed should be placed in the low position, or that he was to be out of his room when he was not in bed.</p> <p>On 2/20/20 at 1:26 PM, the DON said after the 8/4/19 fall they looked at the cause, and wanted Resident #25 to spend his time out of his room to eat and for staff to observe him. She said the care plan was changed to keep Resident #25's door open, so staff could see him due to his poor safety awareness.</p> <p>b. A Post Fall Investigation report documented Resident #25 had an unwitnessed fall with injury on 8/11/19 at 11:30 PM. Resident #25 was found alone and unattended in his room, laying on his right side on the floor between the two beds, with gripper socks on, and verbally expressing he was in pain. The report documented Resident #25 rolled off the bed hitting the bridge of his nose resulting in a 3/4 centimeter (cm) superficial cut and no other injuries. The report documented Resident #25 had been laying on his bed 15 minutes prior to the fall.</p> <p>The Incident Conclusion and Performance Improvement Follow-Up, dated 8/12/19, documented the PI Recommendations were to identify where the staff were at the time for better oversight of Resident #25, and for Occupational Therapy to screen Resident #25.</p> <p>Resident #25's care plan did not include documentation of new interventions related to</p>	F 689			

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F 689	<p>Continued From page 20 this fall.</p> <p>Resident #25's record did not include an Occupational Therapy evaluation and treatment for the month of August.</p> <p>On 2/20/20 at 1:26 PM, the DON said after Resident #25's 8/11/19 fall they evaluated where the staff was at the time of the fall, and requested Occupational Therapy to work with Resident #25, and made a therapy referral for bed safety.</p> <p>c. A Post Fall Investigation report, dated 9/4/19 at 2:00 PM, documented the RN was alerted by staff Resident #25 was on the floor of his room. The RN documented Resident #25 had a skin tear to his left arm which measured 2 cm x 2 cm, he had no pain, and was unable to describe how he fell. The RN wrote it looked like he was on his bed and was heading to the bathroom but fell on his back, with his arms and legs by his side, his feet were towards the bathroom door, with nonskid socks on, he did not use his wheelchair or call light, and did not wait for help. The report documented predisposing factors were a wet floor, Resident #25's recent illness, gait imbalance, impaired memory, and he was ambulating without assistance. The RN documented there was some water on the floor by the bathroom door, and Resident #25's socks were wet.</p> <p>The Incident Conclusion and Performance Improvement Follow-Up, dated 9/5/19, documented the PI Recommendation was to not leave Resident #25 unattended in his room.</p> <p>Resident #25's care plan did not include</p>	F 689			

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F 689	<p>Continued From page 21</p> <p>documentation of new interventions related to this fall.</p> <p>On 2/20/20 at 1:26 PM, the DON said the 9/4/19 fall interventions were Resident #25 was to not be left unattended when up in his room and he was to be in the line of sight. The Administrator said they liked to keep him in the hall and busy.</p> <p>d. A Post Fall Investigation report, dated 9/28/19 at 12:48 AM, documented after hearing a loud door slam, Resident #25 was found sitting on the floor outside of his bathroom, with his shorts around his knees, leaning on his right elbow with a 1 cm skin tear. Resident #25 said he did not hit his head and requested help. The report documented he was assessed for injury, assisted up by 3 staff members, provided first aid to his skin tear, and was assisted into bed. The report documented Resident #25 was oriented to self and situation. The report documented predisposing factors were Resident #25's confusion, gait imbalance, impaired memory, non-compliance, and ambulating and transferring without assistance. The report documented the fall was unwitnessed.</p> <p>The Incident Conclusion and Performance Improvement Follow-Up, dated 9/30/19, documented PI Recommendations were to change Resident #25's straight catheter times, and to scan his bladder for urine and use the straight catheter as needed in order to keep his bladder empty so he did not attempt to get up to the bathroom without assistance.</p> <p>Resident #25's care plan did not include documentation of new interventions related to</p>	F 689			

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F 689	<p>Continued From page 22 this fall.</p> <p>A progress note, dated 9/30/19 at 11:24 PM, documented Resident #25 had increased confusion, he continued to self-transfer, and was unsteady on his feet.</p> <p>On 2/20/20 at 1:26 PM, the DON said Resident #25 had a straight catheter at this time and they reviewed the time of the straight catheterization and did routine bladder scans. The Clinical Resource Nurse said they started his straight catheterizations on 6/19/19, and they were done at 8:00 AM, 2:00 PM, and 8:00 PM. The Clinical Resource Nurse said the report indicated they changed the straight catheterization times, but no change was made in the care plan or Treatment Administration Record (TAR).</p> <p>e. A Post Fall Investigation report documented Resident #25 had an unwitnessed fall on 10/7/19 at 4:40 AM. The report stated Resident #25 was found laying on his right side on the floor of his bedroom between the bed and the wall. The report stated Resident #25 said he rolled out of bed and hit his head. The report documented Resident #25 was assisted up, no bumps or bruising were noted, he was moving all his extremities, his vitals were taken, and his neurological checks were normal for him. The report documented Resident #25 was oriented to person, place, situation, and time. The report documented predisposing factors were Resident #25 was confused, drowsy, incontinent, he had a gait imbalance, and impaired memory.</p> <p>An Incident Conclusion and Performance Improvement Follow-Up report, dated 10/9/19,</p>	F 689			

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F 689	<p>Continued From page 23</p> <p>documented the PI Recommendation was to review Resident #25's straight catheterization timing.</p> <p>Resident #25's care plan did not include documentation of new interventions related to this fall.</p> <p>Resident #25's TAR documented his straight catheterization at 8:00 AM, 2:00 PM and 8:00 PM was discontinued on 10/7/19 and changed to three times a day at 5:00 AM, 1:00 PM and 9:00 PM on 10/7/19.</p> <p>On 2/20/20 at 1:26 PM, the DON said for the 10/7/19 fall they again reviewed the straight catheterization times and an order was placed on 10/7/19 for time changes to 5:00 AM, 1:00 PM, 9:00 PM, and as needed. The Clinical Resource Nurse said the time change did not make it into the care plan, but it was changed on the TAR.</p> <p>f. A Post Fall Investigation documented Resident #25 fell in the dining room on 10/11/19 at 10:30 AM. The report stated Resident #25 stood up from his wheelchair, turned, lost his balance, and fell hitting his head on the edge of the table. The report stated Resident #25 was immediately assessed for injuries with none found and was assisted up and back into his wheelchair. The report documented predisposing factors were Resident #25's confusion, incontinence, weakness, gait imbalance, impaired memory, and ambulating without assistance.</p> <p>The Incident Conclusion and Performance Improvement Follow-Up report, dated 10/14/19, documented a PI Recommendation of "Resident</p>	F 689			

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F 689	<p>Continued From page 24 #25 is impulsive."</p> <p>Resident #25's care plan did not include documentation of new interventions related to this fall.</p> <p>g. A Post Fall Investigation report documented Resident #25 had an unwitnessed fall on 12/6/19 at 4:08 AM. The report documented the RN found Resident #25 in his room laying on the floor on his right side near the wheelchair with his right hand under his head, and his legs extended down. The report documented Resident #25 was confused, had no skin tears, and was able to move his upper and lower extremities. The report documented he was immediately assessed for injury, was assisted up off the floor with a Hoyer lift (a mechanical lift) by three staff members. The report documented predisposing factors as being Resident #25's confusion, gait imbalance, impaired memory, and ambulating without assistance. The report documented Resident #25 became agitated when told to use the wheelchair, and at times was hard to redirect.</p> <p>Resident #25's care plan did not include documentation of new interventions related to this fall.</p> <p>h. A Post Fall Investigation report documented Resident #25 had an unwitnessed fall with major injury on 12/6/19 at 4:15 PM. The report documented Resident #25 was found after staff heard a loud crash and found him in his room on the floor on his left side on the left side of his bed and yelling "I broke my hip." Resident #25 was assessed for injury and found to have his left leg shorter than the right leg and it was turned</p>	F 689			

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F 689	<p>Continued From page 25</p> <p>outward. Predisposing factors for the fall were documented as being Resident #25's confusion, incontinence, gait imbalance, impaired memory, improper footwear, and ambulating without assistance.</p> <p>An Incident Conclusion and Performance Improvement Follow Up report, dated 12/9/19, documented the PI Recommendation was to reassess Resident #25 when he returned from the hospital.</p> <p>A Fall with Injury report documented Resident #25's fall on 12/6/19 at approximately 4:00 PM. The report documented Resident #25 was found on the floor, 20 minutes after the RN last saw him, was assessed and transported to the hospital. The hospital reported Resident #25 had a complex fracture of the left hip from the event. The report documented Resident #25 was severely cognitively impaired and was recently treated for a urinary tract infection. The report's concluding documentation said Resident #25's fracture most likely occurred when he left his bed and fell on the floor. The wheelchair was properly positioned on the other side of the bed, and ready for self-transfer. He left the surface of the bed from the opposite side.</p> <p>A Final Report from the hospital, dated 12/13/19, documented Resident #25's diagnosis was a failed left total replaced hip due to a femur fracture. Resident #25 was discharged and returned to facility on 12/13/19.</p> <p>On 2/20/20 at 2:38 PM, when asked about Resident #25's two falls on 12/6/19, the DON said there was no injury in the morning and it was</p>	F 689			

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F 689	Continued From page 26 not reported and provided the second fall report commenting it was reportable because he broke his hip. On 2/20/20 at 1:26 PM, the DON said for the 10/11/19 fall Speech Therapy and Occupational Therapy became involved related to balance equipment. The DON said Resident #25 kept trying to stand up, so they looked at assistive devices for mobility, including a grab bar which was placed on the wall of his room by the bathroom. The Administrator said therapy was working with Resident #25 on sequencing and his inability to complete tasks without assistance, tactile cues and proper hand placement for a slow decent into a chair. The Administrator said they were trying to work with his memory. The Administrator said Resident #25 "furniture surfed" to move along and stand, and he was able to use the grab bar. When asked about their discussions about supervision as a potential intervention, the Administrator said increased supervision took the form of encouraging Resident #25 to be out of his room or in activities, and on 12/6/19, the day of his fall with hip fracture, he was particularly active, fidgety, and he changed his habits by getting out of bed on his non-usual side, the opposite side of his wheelchair. The facility failed to ensure Resident #25 received the level of supervision and assistance necessary to protect him from injury.	F 689			
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug	F 758		4/8/20	

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F 758	<p>Continued From page 27</p> <p>that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:</p> <p>(i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that---</p> <p>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;</p> <p>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;</p> <p>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and</p> <p>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.</p>	F 758			

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F 758	<p>Continued From page 28</p> <p>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the facility failed to ensure residents were monitored for specific behaviors and side effects for prescribed psychotropic medications. This was true for 1 of 5 residents (Resident #45) reviewed for unnecessary medications. This failed practice created the potential for harm if residents experienced adverse effects from their antidepressant. Findings include:</p> <p>The facility's policy for Unnecessary Medications and Psychotropic Drugs/Antipsychotic Medication, dated 11/28/17, documented the following:</p> <ul style="list-style-type: none"> * "A resident's medication regimen is free of any medication used in excessive dose (including duplicative therapy), excessive duration, without adequate monitoring, without adequate indications for its use, in the presence of adverse consequences or any combination of these reasons." * Medications were monitored for progress towards the goals and to detect any adverse consequences. * The facility assessed the effectiveness of the medications and observed for adverse consequences. 	F 758	<p>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, findings, facts, and conclusions that form the basis for the deficiency.</p> <p>Resident Specific: The ID team reviewed resident #45 for documentation of monitoring for side effects of the antipsychotic and antidepressant medications, and documentation of specific behaviors being monitored for depression. Adjustments have been made as indicated.</p> <p>Other Residents: The ID team reviewed other residents for documentation of monitoring for side effects of the antipsychotic and antidepressant medications, and documentation of specific behaviors being monitored for depression. Adjustments</p>		

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F 758	<p>Continued From page 29</p> <p>The facility's policy for Psychoactive Drug Use, dated 4/4/19, directed staff to implement a behavior monitoring log or similar means to document the need for the medication and response to therapy.</p> <p>These policies were not followed.</p> <p>Resident #45 was admitted to the facility on 11/16/18, with multiple diagnoses including Alzheimer's disease, major depressive disorder, dementia, and insomnia.</p> <p>Resident #45's annual MDS assessment, dated 1/23/20, documented she was severely cognitively impaired, and she received antipsychotic and antidepressant medications on 7 out of the past 7 days.</p> <p>Resident #45's care plan documented she used psychotropic medications related to insomnia, depression, anxiety, and uncontrolled agitation. Interventions included monitoring for side effects and effectiveness, monitoring behaviors, monitoring for medication side effects that may increase fall risk, and notify the physician as needed for side effects and adverse reactions of psychotropic medications.</p> <p>Resident #45's physician orders for February 2020 documented the following:</p> <p>* Cymbalta (antidepressant medication) Delayed Release 60 mg once a day for major depressive disorder. The order started on 12/31/19.</p> <p>* Trazodone (antidepressant medication) 75 mg once a day for insomnia. The order started on 12/30/19.</p>	F 758	<p>have been made as indicated.</p> <p>Facility Systems: Licensed nurses and CNAs are educated to document and monitor side effects of antipsychotic and antidepressant medications, and document specific behaviors being monitored for depression. Re-education was provided by the Chief Nursing Officer to include but not be limited to, monitoring antipsychotic and antidepressant medications and documenting specific behaviors being monitored for depression. The system is amended to include review of the documentation and monitors at the clinical meeting.</p> <p>Monitor: The Chief Nursing Officer and/or designee will audit 5 resident for documentation of monitoring for side effects of antipsychotic and antidepressant medications, and documentation of specific behaviors being monitored for depression for 4 weeks, then 2 residents weekly for 8 weeks. Starting the week of April 8, 2020 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.</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/21/2020
NAME OF PROVIDER OR SUPPLIER CANYON WEST OF CASCADIA			STREET ADDRESS, CITY, STATE, ZIP CODE 2814 SOUTH INDIANA AVENUE CALDWELL, ID 83605		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 758	Continued From page 30 * Zyprexa (antipsychotic medication) 10 mg once a day for major depressive disorder. The order started on 12/31/19. Resident #45's record did not include documentation of monitoring for side effects of the antipsychotic and antidepressant medications. There was also no documentation of specific behaviors being monitored for Resident #45's depression. On 2/21/20 at 10:11 AM, the DON said there was no behavior or side effect monitoring for Resident #45's antidepressant, and there was no side effect monitoring for the antipsychotic medication.	F 758			



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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DAVE JEPPESEN – Director

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

September 1, 2020

Brad Jacobsen, Administrator
Canyon West of Cascadia
2814 S. Indiana Ave.
Caldwell, ID 83605

Provider #: 135051

Dear Mr. Jacobsen:

On February 18, 2020 through **February 21, 2020**, an unannounced on-site complaint survey was investigated in conjunction with a recertification survey at Canyon West of Cascadia. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007978

ALLEGATION #1:

The facility did not appropriately monitor a resident's blood sugar level and blood count, and did not manage her diabetes appropriately.

FINDINGS #1:

Fourteen residents were reviewed for quality care through observations, record review, and interviews with residents, resident representatives, and facility staff. The records of 4 diabetic residents were reviewed for diabetic management. A resident council interview was held with 18 residents in attendance.

Four of four records reviewed for diabetic management documented appropriate blood sugar monitoring and following physician orders regarding diabetic management. The records documented the diabetic medications were administered as ordered, and diabetic protocols were followed according to physician orders and facility policy.

One resident's record documented she had a diagnosis of Type 2 diabetes mellitus, anemia, and gastrointestinal hemorrhage. There were orders in place for diabetic medications upon admission to the facility. The resident received oral medication for diabetes on the night of admission, and received injectable medication for diabetes the next morning. Regular blood sugar monitoring was initiated 2 days after her admission to the facility, and the physician was notified when it was found her blood sugar was very elevated three days after admission to the facility. Orders were received for sliding scale insulin at that time, and her blood sugar was monitored and the sliding scale insulin was administered appropriately during the subsequent days in the facility.

Based on the investigative findings, the allegation could not be substantiated and no deficient practice was found.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The facility failed to provide appropriate incontinence care to residents.

FINDINGS #2:

Fourteen residents were reviewed through observations, record review, and interviews with residents, resident representatives, and facility staff. A resident council interview was held with 18 residents in attendance. Grievances were reviewed for the past 12 months.

During the survey, residents were observed receiving appropriate assistance to the bathroom and appropriate incontinence care, and there were no observed signs of residents being visibly soiled. Residents stated they were receiving appropriate assistance to the bathroom and incontinence care, and there were no documented grievances regarding not receiving assistance to the bathroom or with incontinence care.

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

Brad Jacobsen, Administrator
September 1, 2020
Page 3 of 3

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,

A handwritten signature in black ink, appearing to read "Laura Thompson", is positioned above the typed name.

Laura Thompson, RN, Supervisor
Long Term Care Program

LT/lj



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September 1, 2020

Brad Jacobsen, Administrator
Canyon West of Cascadia
2814 S. Indiana Ave.
Caldwell, ID 83605

Provider #: 135051

Dear Mr. Jacobsen:

On February 18, 2020 through **February 21, 2020**, an unannounced on-site complaint survey was investigated in conjunction with recertification survey at Canyon West of Cascadia. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00008083

ALLEGATION #1:

The facility failed to prevent resident abuse.

FINDINGS #1: .

During the survey, observations were conducted, resident records were reviewed, grievances were reviewed, residents were interviewed, and staff were interviewed.

A Resident Council meeting was held on 2/19/20 with 16 residents in attendance, and no concerns were voiced regarding abuse or neglect.

Record review of the past three months of resident grievances revealed no concerns about abuse or neglect.

No complaints were voiced regarding potential abuse or neglect during interviews with residents during the onsite investigation.

Review of one resident's record found that she was receiving hospice care at home prior

to being admitted to the facility. The resident's spouse had a psychotic episode prior to the resident's admission, and he physically abused her so the hospice agency felt she was no longer safe in the home. The resident had mild cognitive impairment and was physically aggressive with staff after her admission, and she frequently stated that she wanted to return home. It was documented upon the resident's admission that she had areas of bruising, in various stages of healing, scattered over her body. She subsequently had a witnessed fall and sustained additional bruising to her upper torso.

During an interview, the Administrator stated he offered to have the resident's husband admitted to the facility so they could be together, but the daughter did not want them together due to their long history of domestic violence.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The facility failed to ensure a resident's safety, resulting in a possible suicide attempt.

FINDINGS #2:

During the survey, resident records were reviewed, residents were interviewed, and staff were interviewed.

Review of one resident's record found that she had no prior history of suicidal ideation or attempts prior to her admission to the facility. The psychiatrist saw the resident after an alleged suicide attempt in the facility. According to the psychiatrist's progress note, he was not convinced the resident was truly attempting suicide. The psychiatrist recommended no significant changes to her medications or regimen because he felt there was no actual suicide attempt made. He noted that long term care (LTC) would be in the best interest of the resident because her spouse could no longer care for her at home.

During an interview, the Administrator stated that he spoke to the resident the day after the alleged incident, and she stated she was definitely not making a suicidal attempt, but she was attempting to "...blow open ..." the plastic bag to put something in it." The Administrator stated the resident told him she really wanted to go home to be with her husband.

The Administrator stated he offered to have the resident's husband admitted to the

Brad Jacobsen, Administrator
September 1, 2020
Page 3 of 3

facility so they could be together, but the daughter did not want them together due to their long history of domestic violence.

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,

A handwritten signature in black ink, appearing to read "Laura Thompson".

Laura Thompson, RN, Supervisor
Long Term Care Program

LT/lj



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September 1, 2020

Brad Jacobsen, Administrator
Canyon West of Cascadia
2814 S. Indiana Ave.
Caldwell, ID 83605

Provider #: 135051

Dear Mr. Jacobsen:

On **February 21, 2020**, an unannounced on-site complaint survey was conducted at Canyon West of Cascadia. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00008135

ALLEGATION #1:

The facility failed to ensure care and services were provided per resident request.

FINDINGS #1:

An onsite recertification and complaint survey was conducted from 2/18/20 through 2/21/20. During the survey, observations were conducted, resident records were reviewed, grievances were reviewed, residents were interviewed, and staff were interviewed.

A Resident Council meeting was held on 2/19/20 with 16 residents in attendance, and no concerns were voiced regarding abuse or neglect.

Review of the previous three months of resident grievances found no concerns about abuse or neglect.

No complaints were voiced regarding potential abuse or neglect during interviews with residents during the onsite investigation.

One resident was observed in her room, and she appeared to be asleep in bed. She was appropriately groomed and free of any odors. The same resident was later observed lying in bed in her room. She had just finished her shower and was being assisted by the shower aide to style her hair.

During an interview with the resident, she stated the Director of Nursing and Social Worker worked with her to accommodate many of her preferences, such as increasing her showers to 3 times a week and letting her sleep later in the morning. She also stated she thought about moving to another facility, but she liked it at the facility and she did not want to move. She further stated that the problem that occurred in June 2019 had not happened since then, and she confirmed she had received a shower that afternoon.

The resident's shower schedule was reviewed, and it showed showers were scheduled 2 times a week and as needed. It was documented the resident received a total of 12 showers in June 2019.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The facility failed to ensure meals were served in a timely manner.

FINDINGS #2:

During interviews with residents during the onsite investigation, no complaints were voiced regarding meals not being served in a timely manner.

A Resident Council meeting was held on 2/19/20 with 16 residents in attendance, and no concerns were voiced regarding meal service.

During an observation, one resident's meal tray was delivered to her room. She stated she was not that hungry and she probably would not eat.

During an observation on the following day, the same resident stated her meals were occasionally running late due to some recent staff changes in the dietary department. The resident stated she received her meals, but she was not always hungry when her meals arrived and sometimes she would not eat. The resident stated when that occurred, she would ask for something else and she received it.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Brad Jacobsen, Administrator
September 1, 2020
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ALLEGATION #3:

The facility failed to ensure residents were free from neglect.

FINDINGS #3:

During the onsite investigation, no complaints were voiced about the facility Administration/Personnel being neglectful.

In an interview, one resident recalled a time that she did not recognize a named nurse who came to talk to her because she had not met her before that time. The resident also stated she currently knew exactly who the nurse was, but she was unable to recall any specifics regarding the nurse or any other staff member refusing to move her phone within her reach. At the time of the interview, the resident's phone was observed on her over bed table and was within her reach. The resident stated she did feel safe in the facility, and she did not feel she had been neglected or lied to.

A Resident Council meeting was held with 16 alert residents in attendance. There were no concerns voiced regarding Administration/Personnel being neglectful.

Record review of the past three months of resident grievances revealed no concerns about abuse or neglect.

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,



Laura Thompson, RN, Supervisor
Long Term Care Program

LT/lj

Brad Jacobsen, Administrator
September 1, 2020
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September 1, 2020

Brad Jacobsen, Administrator
Canyon West of Cascadia
2814 S. Indiana Ave.
Caldwell, ID 83605

Provider #: 135051

Dear Mr. Jacobsen:

On **February 18, 2020** through **February 21, 2020**, an unannounced on-site complaint survey was investigated at Canyon West of Cascadia in conjunction with a recertification survey. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00008196

ALLEGATION #1:

The facility failed to notify a resident's representative of a fall in a timely manner.

FINDINGS #1:

Fourteen residents were reviewed through observations, record review, and interviews with residents, resident representatives, and facility staff. A resident council interview was held with 18 residents in attendance. Grievances were reviewed for the past 12 months. The records of three residents were reviewed specifically for falls.

There were no expressed concerns from residents or their representatives, and there were no grievances regarding notification of falls. Three of three resident records documented their representative was notified in a timely manner regarding resident falls.

One resident's record documented she fell on 7/26/19 and 7/28/19, and her family

member was notified on the same day of each fall.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The facility failed to ensure residents received appropriate incontinence care in a timely manner.

FINDINGS #2:

An investigation was conducted during an onsite complaint survey in conjunction with a recertification survey from February 18, 2020 through February 21, 2020.

Fourteen residents were reviewed through observations, record review, and interviews with residents, resident representatives, and facility staff. A resident council interview was held with 18 residents in attendance. Grievances were reviewed for the past 12 months.

During the survey, residents were observed receiving appropriate assistance to the bathroom and appropriate incontinence care, and there were no observed signs of residents being visibly soiled. Residents stated they were receiving appropriate assistance to the bathroom and incontinence care, and there were no documented grievances regarding not receiving assistance to the bathroom or with incontinence care.

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

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The facility failed to provide adequate staff to meet residents' needs.

FINDINGS #3:

Brad Jacobsen, Administrator
September 1, 2020
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Fourteen residents were reviewed through observations, record review, and interviews with residents, resident representatives, and facility staff. A resident council interview was held with 18 residents in attendance. Grievances were reviewed for the past 12 months. The facility's nurse staffing was reviewed for the 3 weeks prior to the survey and for the entire month during the time period of concern.

During the survey, staff were observed meeting resident needs and call lights were answered in a timely manner. The reviewed nurse staffing met the regulatory requirements for all days reviewed. There were no confirmed instances of resident needs that were not met due to insufficient staff.

Based on the regulatory 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,



Laura Thompson, RN, Supervisor
Long Term Care Program

LT/lj



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HEALTH & WELFARE

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BUREAU OF FACILITY STANDARDS
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P.O. Box 83720
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PHONE: (208) 334-6626
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E-mail: fsb@dhw.idaho.gov

September 2, 2020

Brad Jacobsen, Administrator
Canyon West of Cascadia
2814 S. Indiana Ave.
Caldwell, ID 83605

Provider #: 135051

Dear Mr. Jacobsen:

On **February 18, 2020** through **February 21, 2020**, an unannounced on-site complaint survey was investigated in conjunction with a recertification survey at Canyon West of Cascadia. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00008247

ALLEGATION #1:

The facility did not prevent pressure ulcers.

FINDINGS #1:

During the survey, observations were conducted, resident records were reviewed, residents were interviewed, and staff were interviewed.

Four resident records were reviewed for wounds and pressure ulcers. One resident's record documented he was admitted for a below the knee amputation with a surgical incision. The resident's record included a physician's order for a splint to keep the knee from bending, in preparation for a prosthesis in the future. A nursing progress note, documented as a late entry, documented a concern about the resident's brace. The nursing note stated the brace was removed and there were three marks on the resident's rear upper thigh. The marks were documented as linear and one was documented as red in color and the other two were brown in color. The note documented the marks were blanchable. The resident's record included visit notes from a wound care clinic.

he wound notes documented the wound clinic was treating the surgical wound from the

resident's surgical amputation. There was no documentation in the wound clinic notes of marks or wounds on the resident's rear thigh from his brace. During the survey, the Staff Development Coordinator (SDC) stated she was the resident's primary care nurse during his stay in the facility. The SDC stated the resident did not complain about the brace and was able to take it on and off by himself. The SDC stated the brace would have left some dark lines on the resident's upper leg if he was up in his wheelchair for a period of time.

Another resident who was readmitted to the facility in October 2019, with diagnoses of diabetes mellitus, heart failure, and peripheral vascular disease, had wounds which were being treated by a wound care clinic. A wound care clinic progress note, signed by the Nurse Practitioner, documented the resident had a stasis ulcer to his right lower leg, a diabetic wound on his left heel, and moisture associated skin damage to his buttocks which was chronic. The resident was seen by the wound care clinic on a regular basis. The most recent progress note from the NP documented the resident's left heel wound was slowly improving and the redness to his buttocks was chronic and he had some breakdown but no open areas. During the survey, the resident stated he had one small pressure sore on his bottom that was smaller than his little fingernail. He stated when he was admitted to the facility eight years ago his bottom looked like hamburger meat, but it had healed. Review of the resident's record did not find documentation of pressure ulcers on his buttocks, and he was being treated for a venous ulcer on the left lower leg and chronic diabetic ulcer on the left heel.

Based on the investigative findings, the allegation could not be substantiated due to lack of sufficient evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The staff did not notify the physician when residents had a significant change in their condition.

FINDINGS #2:

During the survey, resident records were reviewed, residents were interviewed, and staff were interviewed.

Four resident records were reviewed. One resident's closed record (meaning the resident no longer resided in the facility) documented the resident had multiple chronic medical conditions. A progress note, by the Nurse Practitioner (NP), documented an evaluation of the resident was performed when he was notified by nursing staff that the resident was more confused than normal.

The note documented the resident requested to go to the hospital; however, the NP told the

resident he would order lab work to be done. The NP documented the resident had a history of chronic hypoxic respiratory failure (insufficient oxygen throughout the body), and he was noncompliant with using his oxygen supplementation. The resident had been exhibiting confusion and urinary retention, and he had to be catheterized. The laboratory results were not significantly changed from previous lab results.

A subsequent nursing progress note stated, "Multiple behaviors, will just stand next to bed, will call for staff to move his legs in bed. yelling out for help. Won't use call light. When staff next to bed will push on call light. Turned self on his stomach, yelling for help. Assisted by 4 staff. Keeps removing O2 (oxygen) tubing."

The next day, a nursing progress note documented, "NP notified of increased weakness and shaking, slow responses to questions, difficulty answering questions. Orders for stat labs. Results sent to NP gave order to send to the hospital for evaluation related to elevated ammonia levels and acute renal failure."

A hospital physician's progress note documented diagnoses of severe sepsis (a potentially life-threatening condition caused by the body's response to an infection), aspiration pneumonia, acute kidney failure, hepatorenal syndrome (a type of progressive kidney failure seen in people with severe liver damage, most often caused by cirrhosis), metabolic and hepatic encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition such as viral infection or toxins in the blood), cirrhosis (a chronic disease of the liver), hyperammonemia (excess ammonia in the blood which may lead to brain injury and death), acute urinary retention, and congestive heart failure. Over the course of the hospitalization the resident's condition declined.

The resident returned to the facility 4 days later, with orders for comfort care for end of life care.

Another resident was readmitted to the facility in January 2020, after being sent to the hospital for evaluation. The resident had multiple diagnoses including spina bifida (a birth defect that occurs when the spine and spinal cord do not form properly), hemiplegia and hemiparesis (weakness and paralysis) affecting the right side following a stroke, neuropathic bladder (a bladder that does not empty or store urine properly due to a neurological condition or spinal cord injury), and history of traumatic brain injury.

A progress note documented the resident had a distended (swollen) abdomen with decreased bowel sounds. The note documented the resident told the nurse he had not had a bowel movement in two weeks. The note also documented the resident's blood pressure was 82/54, his heart rate was 91, and his temperature was 99.0 F. (Fahrenheit). The nurse documented the resident was medicated for his temperature and given a Dulcolax suppository (laxative). There was no documentation his physician was notified of his low blood pressure and that he had a distended abdomen with no bowel movement in two weeks. A subsequent progress note documented the resident complained of "extreme pain," and he

Brad Jacobsen, Administrator
September 2, 2020
Page 4

was perspiring profusely. His blood pressure was 88/58, the heart rate was 118, and his temperature was 101 F. The resident was sent to the emergency room.

A history and physical note from the hospital stated the resident presented to the Emergency Room with rapid breathing and hypotension (low blood pressure). He was admitted to the hospital with severe sepsis, community acquired pneumonia, urinary tract infection, and Influenza A.

Based on the investigative findings, the allegation was substantiated and the facility was cited at F580 as it related to the failure to notify the physician of a significant change in condition.

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,



Belinda Day, RN, Supervisor
Long Term Care Program

BD/lj