

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065228	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2024
NAME OF PROVIDER OR SUPPLIER Canyon View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 151 E 3rd St Palisade, CO 81526	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death.</p> <p>50314</p> <p>Based on record review and interviews, the facility failed to ensure the money from personal funds accounts was managed adequately for two (#7 and #13) of five residents reviewed for personal funds out of 41 sample residents.</p> <p>Specifically, the facility failed to notify Resident #7 and Resident #13, who were Medicaid funded, or their legal representative, when the resident's personal funds account reached \$200.00 less than the eligibility resource limit for one person.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Management of Residents' Personal Funds policy, revised March 2021, was provided by the nursing home administrator (NHA) on 7/23/24 at 5:15 p.m. It documented in pertinent part, The facility manages the residents' funds, the facility acts as a fiduciary of the resident funds and holds, safeguards, manages and accounts for the personal funds of the resident. No service charge is levied against the resident for the management of personal funds.</p> <p>II. Record Review</p> <p>A. Resident #7</p> <p>A review of the facility's current trust account balance on 7/18/24 revealed Resident #7 had \$2,083.69 in her account, which was \$83.69 over the allotted \$2000.00 eligibility limit for Medicaid funded residents.</p> <p>-There was no documentation to indicate the facility had notified Resident #7 or her legal representative when her personal funds account reached \$200 less than the eligibility resource limit.</p> <p>B. Resident #13</p> <p>A review of the facility's current trust account on 7/18/24 revealed Resident #13 had \$1,876.24 in her account.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-There was no documentation to indicate the facility had notified Resident #13 or her legal representative when her personal funds account reached \$200 less than the eligibility resource limit.</p> <p>III. Staff interviews</p> <p>The business office manager (BOM) was interviewed on 7/22/24 at 3:04 p.m. The BOM said she had not provided letters to Resident #7 and Resident #13 stating they were within \$200 of the Medicaid spending limit. The BOM said she was trained by the regional personnel at the same time as a few other BOM's at other health care facilities. She said she was concerned that some business office education may have been lost in the training process.</p> <p>The nursing home administrator (NHA) and the director of nursing (DON) were interviewed together on 7/23/24 at 4:53 p.m. The NHA said she was not aware that Medicaid letters had not been sent when residents were within \$200 of the spending limit.</p> <p>The DON said Medicaid spending limit letters should be provided to residents.</p>

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>50314</p> <p>Based on observations and interviews, the facility failed to ensure residents' personal privacy for two (#18 and #49) of three residents reviewed for privacy out of 41 sample residents.</p> <p>Specifically, the facility failed to ensure residents had privacy during personal phone calls.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Promoting/Maintaining Resident Dignity policy, dated 1/1/23, was provided by the nursing home administrator (NHA) on 7/23/24 at 5:15 p.m. It documented in pertinent part,</p> <p>All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights.</p> <p>Maintain resident privacy.</p> <p>II. Observations</p> <p>On 7/17/24 at 10:05 a.m., an unidentified resident was observed using the landline telephone at the nurse's station. Two staff members were sitting close by in the nurses station within a few feet of the resident.</p> <p>-No privacy was provided to the unidentified resident.</p> <p>On 7/19/24 at 1:41 p.m., Resident #18 was observed at the nurse's station. The resident was talking on the landline telephone. During the telephone conversation, the resident had to repeat herself in a louder voice so she could be heard on the telephone. Multiple nursing staff and residents were present within the immediate area of the telephone conversation which was easily overheard.</p> <p>-No privacy was provided to the resident.</p> <p>On 7/23/24 at 9:11 a.m., Resident #18 was observed at the nurse's station. The resident was talking on the landline telephone. The resident used her hands to attempt to block sound from the room going into the mouthpiece of the landline telephone. Multiple nursing staff and residents were present within the immediate area of the telephone conversation, which was easily overheard.</p> <p>-No privacy was provided to the resident.</p> <p>III. Resident interviews</p> <p>(continued on next page)</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #49, who was cognitively intact, was interviewed on 7/18/24 at 10:33 a.m. Resident #49 said he was not able to make private phone calls in the facility if his personal cell phone stopped working. Resident #49 said his personal cell phone ran out of battery power a month ago (June 2024) and he was unable to have private phone conversations with his wife on the facility phone. Resident #49 said he had to use the phone at the nurse's station to speak to his wife which made him uncomfortable because there were multiple staff members and residents within a few feet of him listening to the conversation. Resident #49 said since the incident when his phone ran out of battery power he ensured his phone was fully charged every day so he did not have to use the community phone at the nurse's station.</p> <p>Resident #18, who was cognitively intact, was interviewed on 7/22/24 at 3:12 p.m. Resident #18 said she could not make a private phone call in the facility. Resident #18 said her only option to make any phone call was to use the landline phone at the nurse's station. Resident #18 said she did not like to use the landline phone at the nurse's station because she knew staff and other residents listened to her telephone conversations. Resident #18 said she had heard nursing staff make comments about her telephone conversations while she was talking on the landline phone, which made her feel uncomfortable.</p> <p>Resident #49 was interviewed again on 7/23/24 at 10:58 a.m. Resident #49 said he did not know there were cell phones for resident use. Resident #49 said the staff in the facility had not informed him that cell phones for resident use were available. Resident #49 said he wished he had known about the option when he needed to make private phone calls and his personal cell phone was not available to him.</p> <p>Resident #18 was interviewed again on 7/23/24 at 12:56 p.m. Resident #18 said she was not aware the facility had cell phones for residents to use. Resident #18 said she was never informed by staff that cell phones were available for resident use. Resident #18 said she would like to use the cell phones for private phone calls in her room if that was available to her.</p> <p>III. Resident group interview</p> <p>Four residents (#16, #49, #59 and #65), who were identified as interviewable by the facility and assessment, were interviewed on 7/22/24 at 9:30 a.m. The following comments were made regarding privacy when making or receiving phone calls:</p> <ul style="list-style-type: none"> -Residents said there was a shared phone available at the nurse's station on the south unit or residents could use the phone at the front desk. -The facility had cell phones but the residents had been told the cell phones were lost. -A resident said when she had to make a phone call at the nurse's station, she did not have privacy because there were staff and other residents all around her. -Another resident said if she wanted to have a private phone call she would have to ask staff to borrow one of their personal phones. <p>IV. Staff interviews</p> <p>(continued on next page)</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Licensed practical nurse (LPN) #2 was interviewed on 7/23/24 at 10:11 a.m. LPN #2 said the facility had two cell phones that the residents could use but she did not know where they were located. LPN #2 said the cell phones for resident use should be kept at the nurse's station. LPN #2 said she did not know when the cell phones were last requested for personal use.</p> <p>LPN #2 was interviewed again on 7/23/24 at 10:24 a.m. LPN #2 said the cell phones for resident use were now being kept at the front desk. LPN #2 said she did not know when this change occurred. LPN #2 said the residents should know that cell phones were available to them. LPN #2 said she did not know when the cell phones first became available for the residents.</p> <p>Certified nurse aide (CNA) #7 was interviewed on 7/23/24 at 10:41 a.m. CNA #7 said she did not know if there were personal cell phones for the residents to use. CNA #7 said she had not been asked for a cell phone to make a private phone call in the facility.</p> <p>The director of nursing (DON) was interviewed on 7/23/24 at 4:53 p.m. The DON said the residents should have privacy during phone calls to respect the residents ' dignity and privacy. The DON said the facility should do more to inform the residents that cell phones were available for their personal use. The DON said she would type up a newsletter to distribute to the residents to ensure they were aware that the cell phones were available to them.</p> <p>The NHA was interviewed on 7/23/24 at 7:33 p.m. The NHA said she had not identified resident phone call privacy as an issue in the QAPI committee.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48412</p> <p>Based on record review and interviews, the facility failed to ensure residents were kept free from abuse for one (#29) of four residents reviewed for abuse out of 41 sample residents.</p> <p>Specifically, the facility failed to protect Resident #29 from physical abuse by Resident #44.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Abuse policy, revised 2/29/24, was provided by the nursing home administrator (NHA) on 7/22/24 at approximately 12:00 p.m. It read in pertinent:</p> <p>Residents have the right to be free from abuse. This includes but is not limited to verbal and physical abuse.</p> <p>The resident's care plan is revised to include new approaches to reduce or eliminate any further chance of abuse. Recommendations for appropriate intervention can then be implemented. When another resident jeopardizes the safety of one resident, alternative placement may be considered for that resident.</p> <p>II. Incident of physical abuse between Resident #44 and Resident #29 on 7/2/24</p> <p>A. Facility investigation of the altercation on 7/2/24</p> <p>The initial report, completed 7/2/24, documented two female residents in the secured dementia unit had a verbal and physical altercation. Resident #44 and Resident #29 shared a bedroom, where this incident occurred. Resident #44 told Resident #29 to shut up. Resident #29 responded with I do not have to, you are not my boss.</p> <p>Resident #44 pushed Resident #29 which resulted in Resident #29 falling to the ground. The staff immediately separated the residents for the night and Resident #29 was placed on 15-minute checks. The nurse assessed the residents and Resident #29 had a bruise to her left elbow. Certified nurse aide (CNA) #6 was interviewed and said she heard a commotion and checked in the resident's room. CNA #6 separated the residents for the night because they shared a room.</p> <p>A summary of the investigation revealed Resident #44 did push Resident #29 to the ground which resulted in a bruise. The allegation of the resident to resident altercation was substantiated by the facility.</p> <p>III. Resident #44 (assailant)</p> <p>A. Resident status</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #44, age 73, was admitted on [DATE]. According to the July 2024 computerized physician orders (CPO), diagnoses included Wernicke's encephalopathy (life-threatening illness caused by thiamine deficiency) and dementia.</p> <p>The 6/27/24 minimum data set (MDS) assessment revealed Resident #44 had a severe cognitive impairment with a brief interview for mental status (BIMS) score of zero out of 15.</p> <p>The MDS assessment indicated Resident #44 did not have behaviors.</p> <p>B. Record review</p> <p>A change of condition was completed for Resident #44 on 7/2/24. Resident #44 was documented as having had behavioral symptoms. Resident #44 exchanged aggressive words with her roommate, Resident #29, and shoved Resident #29 which caused her to fall. Resident #29 and Resident #44 were separated and Resident #29 was in another room for the night.</p> <p>A progress note dated 7/2/24 documented Resident #44 was unable to recall an incident that occurred with her roommate (Resident #29). Resident #44 and Resident #29 were separated and 15-minute checks were initiated. The nursing home administrator (NHA), the on-call nurse and the physician were notified.</p> <p>Resident #44's care plan, revised 7/3/24, documented the resident had the potential to become verbally or physically aggressive toward other residents. Interventions included ensuring the resident had a routine, providing redirection if the resident had escalating behavior, redirecting the resident when she approached other residents and redirecting other residents from Resident #44's bedroom.</p> <p>An interdisciplinary team (IDT) risk management note dated 7/3/24 documented the root cause of the incident was because Resident #44 was territorial and she was adjusting to a new roommate. The interventions that were put into place after the altercation were 15-minute checks and the residents were to be monitored for adjustment of becoming roommates.</p> <p>IV. Resident #29 (victim)</p> <p>A. Resident status</p> <p>Resident #29, age greater than 65, was admitted on [DATE]. According to the July 2024 CPO, diagnoses included anxiety disorder, insomnia, dementia that was moderate with anxiety and Alzheimer's disease.</p> <p>The 4/30/24 MDS assessment revealed Resident #29 had severe cognitive impairment with a BIMS score of zero out of 15.</p> <p>The MDS assessment did not indicate Resident #29 had any behaviors.</p> <p>B. Record review</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A change of condition was completed for Resident #29 on 7/2/24. Documentation revealed she had a fall. Resident #29 was observed on the floor next to her bed on her hands and knees. Resident #29 said Resident #44 pushed her after the residents exchanged words. Resident #29 had minor pain in her left elbow. Resident #29's left elbow had an area that was two inches in diameter that was slightly discolored. The residents were separated and 15-minute checks were started.</p> <p>A progress note dated 7/2/24 documented in Resident #29's EMR verbalized Resident #44 shoved her and she fell . A blue bruise about two diameters in size was noted on her left elbow.</p> <p>An IDT note was entered in Resident #29's EMR on 7/3/24. It documented the resident received physical aggression. The root cause was identified as the residents were adjusting to a room change. The residents were separated, 15-minute checks were started and Resident #29's bruise was monitored.</p> <p>V. Staff interviews</p> <p>Certified nurse aide (CNA) #1 was interviewed on 7/17/24 at 12:42 p.m. CNA #1 said the staff attempted to keep the residents separated if residents appeared upset. She said separation did not always work because the residents on the unit had dementia.</p> <p>CNA #5 was interviewed on 7/17/24 at 12:45 p.m. CNA #5 said staff kept a close eye on all of the residents in the dementia unit. CNA #5 said she had not witnessed a lot of resident to resident altercations on the unit. CNA #5 said the residents mainly yelled at each other. CNA #5 said the activity staff were supposed to help entertain the residents while nursing staff provided the residents' care.</p> <p>Licensed practical nurse (LPN) #4 was interviewed on 7/23/24 at 3:57 p.m. LPN #4 said the residents who had dementia were in an altered mental state but that was to be expected because that's how the residents were.</p> <p>The memory care director (MCD) was interviewed on 7/23/24 at 4:06 p.m. The MCD said the staff watched the residents who had a diagnosis of dementia very closely. She said the staff kept the resident's doors open and had staff who walked the hallways to keep an eye on the residents. She said staff offered snacks, cookies and popcorn throughout the day. The MCD said the staff were vigilant and kept an eye on the residents to prevent resident to resident altercations. She said some of the shared resident rooms were in close quarters to each other. The MCD if staff noticed any type of escalation, yelling, cussing or facial expressions the staff redirected the resident. The MCD said when the weather was cooler the staff brought the residents outside to entertain the residents.</p> <p>The nursing home administrator (NHA) was interviewed on 7/23/24 at 6:21 p.m. The NHA said she was not at the facility when the resident to resident altercation between Resident #44 and Resident #29 occurred. The NHA said Resident #44 and Resident #29 were roommates. The NHA said on the night of the incident (7/2/24) the residents did not remember they were roommates which started a verbal altercation. She said the staff separated the residents and there were no further incidents between the residents. The NHA said Resident #44's care plan was updated but Resident #29's care plan was not because she was the victim and staff did not think to update it.</p>		

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40467</p> <p>Based on observations, record review and interviews, the facility failed to provide treatment and services to maintain hearing in a timely manner for one (#3) of one resident reviewed out of 41 sample residents.</p> <p>Specifically, the facility failed to ensure recommendations for Resident #3 were followed after an audiologist appointment.</p> <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Ancillary Services policy, dated 11/4/13, was provided by the nursing home administrator (NHA) on 7/23/24 at 5:15 p.m. The policy read in pertinent part, Any resident needing or requesting ancillary services, such as dental, vision, audiology and podiatry will have their needs met timely. The facility will keep available a provider for ancillary services and/or assist the resident with utilizing the provider of their choice.</p> <p>II. Resident status</p> <p>Resident #3, age greater than 65, was admitted on [DATE]. According to the July 2024 computerized physician orders (CPO), diagnoses included unspecified intracranial injury with loss of consciousness (head injury), anxiety, major depressive disorder post-traumatic stress disorder and unspecified perpetrator of maltreatment and neglect.</p> <p>The 4/29/24 minimum data set (MDS) assessment indicated Resident #3 had moderate cognitive impairments with a brief interview for mental status (BIMS) score of 10 out of 15. He did not have inattention or disoriented thinking. No behavioral symptoms or care rejection were documented. The resident required limited one-person physical assistance with most activities of daily living (ADL).</p> <p>According to the MDS assessment, the resident's hearing was adequate and he did not use hearing aids.</p> <p>III. Resident interview</p> <p>Resident #3 was interviewed on 7/17/24 at 1:52 p.m. Resident #3 said he had not gone to bingo lately because he had not been able to hear well enough to play. He said he had difficulty hearing and had been asking to go to the physician to get his ears tested . He said he was supposed to have his ears tested a while ago but he never heard anything more about it.</p> <p>Resident #3 was interviewed again on 7/23/24 at 4:28 p.m. Resident #3 said he was very happy because he was told the nurse was going to put drops in his ears so he could have his ears tested . He said he had been waiting to have his hearing checked for a long time (see record review and interviews below).</p> <p>(continued on next page)</p>

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>IV. Record review</p> <p>The 2/13/23 patient appointment visit information form identified Resident #3 had a physician's order to schedule an appointment with the physician/nurse for ear wax removal. According to the physician's orders, the resident had too much wax to test (Resident #3's hearing). The information form requested the facility to look in the resident's ears before scheduling an appointment and if there was a lot of earwax, remove the wax prior to the appointment.</p> <p>The 7/28/23 weekly nursing note read Resident #3 had difficulty hearing in some environments. A speaker may be needed to increase the volume or speak distinctly.</p> <p>-Review of Resident #3's physician's orders did not identify that the resident had orders to remove the earwax after the failed attempt to test his hearing with the specialist.</p> <p>-Review of Resident #3's progress notes did not identify the resident's earwax was removed and another appointment was made to test his hearing.</p> <p>-Review of the resident's comprehensive care plan revealed he did not have a care plan regarding hearing, difficulty hearing, or interventions to help with his difficulties in hearing.</p> <p>V. Staff interviews</p> <p>The social services director (SSD) and the NHA were interviewed together on 7/22/24 at 4:16 p.m. The SSD said when a resident returned to the facility after an appointment, the nurse would enter the new orders, recommendations and/or referrals in the resident's electronic medical record (EMR). The SSD said an appointment would be scheduled for follow up as needed. The SSD said she was not aware of the concerns with Resident #3's hearing.</p> <p>The NHA and the SSD said they reviewed the resident's EMR.</p> <p>The NHA said the resident last went to the audiologist on 2/13/23. She said the audiologist requested for Resident #3's excess earwax to be removed so his hearing could be tested . The NHA said she did not see an order to remove the excess earwax. She said she did not see documentation that the audiologist's orders were followed. The NHA and the SSD said neither of them were in their current positions in February 2023 and they were not sure why the recommendations were not followed up with at the time of the audiology appointment.</p> <p>The SSD said she would notify the director of nursing (DON) and the nurse practitioner of the orders and schedule a follow up appointment with the audiologist to test Resident #3's hearing. The SSD said she would create a grievance form to make sure the needed steps to correct the concern were taken, tracked and reviewed in the interdisciplinary team's (IDT) meeting.</p> <p>The DON was interviewed on 7/23/24 at 3:14 p.m. The DON said when a resident went to a specialist, the resident's nurse would review the visit summary, put the recommendations in the EMR as verbal orders and notify the nurse practitioner. She said she was informed on 7/22/24 (during the survey) Resident #3 was having a harder time hearing. The DON said she discussed the concern with the physician and the resident had a new physician's order for ear drops to help with his earwax removal.</p> <p>(continued on next page)</p>		

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The DON said an appointment would be made when Resident #3's earwax buildup was clear. She said she did not know how the orders were missed, but the facility had implemented a new double check process to make sure all physician's orders were put into the EMR after recommendations were made from a specialist, following the appointment.</p> <p>The activity director (AD) was interviewed on 7/23/24 at 6:29 p.m. The AD said Resident #3 had not been going to bingo as much as he used to and, over the last couple of months, he stopped going completely. She said she was not aware Resident #3 was having a hard time hearing. She said she could have offered to have him sit by her during bingo so he could hear the numbers called out.</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50314</p> <p>Based on observations, record review and interviews, the facility failed to provide an effective pain management regimen in a manner consistent with professional standards of practice, the comprehensive person-centered care plan and the resident's goals for one (#49) of two residents reviewed for pain out of 41 sample residents.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> -Consistently and accurately assess Resident #49's pain to ensure the resident's pain was at or below the resident's stated tolerable pain level; -Ensure Resident #49's care plan included person-centered non-pharmacological interventions for pain; and, -Ensure the physician's order for routine pain medication for Resident #49 was administered as ordered. <p>Findings include:</p> <p>I. Facility policy and procedure</p> <p>The Pain Management policy, dated 5/3/23, was provided by the nursing home administrator (NHA) on 7/23/24 at 5:15 p.m. It revealed in pertinent part,</p> <p>Acceptable (tolerable) pain control is defined by the resident.</p> <p>All residents will be evaluated for pain by utilizing a pain evaluation tool in the electronic medical record (EMR) system. The pain evaluation will be completed upon admission, readmission, quarterly, and with any significant change in condition.</p> <p>The pain evaluation includes the following: location(s), quality, intensity, associated symptoms, precipitating, aggravating, and relieving factors, chronology, pattern (frequency, onset and duration of pain), medication regimen and other treatment modalities used for pain management and their degree of effectiveness.</p> <p>II. Resident #49</p> <p>A. Resident status</p> <p>Resident #49, age less than 65, was admitted on [DATE]. According to the July 2024 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease (COPD), right leg amputation below the knee, aortic heart valve disorder, peripheral vascular disease (narrowed blood vessels), chronic kidney disease, type two diabetes, diabetic neuropathy (nerve damage caused by diabetes) and generalized muscle weakness.</p> <p>(continued on next page)</p>

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The 7/8/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview mental status (BIMS) score of 15 out of 15. The assessment documented Resident #49 had a limb prosthesis and used both a walker and a wheelchair.</p> <p>The assessment documented Resident #49 was on a scheduled pain regimen and did not receive as-needed pain medications or non-medication interventions for pain in the last five days during the assessment period.</p> <p>The assessment documented the resident occasionally had pain, but the pain did not interfere with the resident's sleep or participation with therapy. The resident's pain rarely interfered with his day to day activities. The resident's occasional pain was mild in intensity.</p> <p>B. Observations</p> <p>On 7/22/24 at 4:23 p.m., medication pass was observed with licensed practical nurse (LPN) #5. After preparing other medications for Resident #49, LPN #5 prepared pain medication. LPN #5 opened the narcotic medication lockbox, removed one oxycodone-acetaminophen 5-325 milligram (mg) tablet and placed the tablet into a medication cup. LPN #5 closed the narcotic medication box and locked the medication cart. LPN #5 turned away from the medication cart with the intention to deliver the medications to Resident #49.</p> <p>Upon prompting, LPN #5 reread Resident #49's physician's order for oxycodone-acetaminophen. LPN #5 said she did not know if she could give the medication to the resident at 5:00 p.m. because the physician's order was confusing on when to administer the medication. LPN #5 asked for help from LPN #2 and the director of nursing (DON). The DON clarified and updated the physician's order in the July 2024 CPO on 7/22/24. (see interview below)</p> <p>B. Resident interviews</p> <p>Resident #49 was interviewed on 7/18/24 at 10:33 a.m. Resident #49 said he had pain throughout all hours of the day and it often felt severe for him. Resident #49 said he recently received a prosthetic leg, but it caused him pain wearing it, so he did not wear the prosthetic as much as he would like.</p> <p>Resident #49 said he felt his pain limited his ability to perform activities of daily living (ADL) and limited his sleep. Resident #49 said he normally only slept a few hours each night and it was usually in the early morning when sleep occurred.</p> <p>Resident #49 said he felt constant phantom pain (a painful sensation that is perceived in a body part that is no longer present due to surgical or traumatic removal) in his right leg from the amputation and he had some occasional pains in his hands that felt like lightning to him. Resident #49 said he had tried several nerve pain medications, such as gabapentin and Lyrica, but they did not help his pain. He said the medications he was receiving did not bring his pain to a tolerable level. Resident #49 said that his pain level was a 7 or 8 out of 10 throughout the day, and his acceptable level of pain was a 3 out of 10.</p> <p>Resident #49 said he used lotion for his hands to relieve pain between pain medication doses, but that only reduced his pain a little and did not relieve his pain.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #49 said sometimes the nursing staff did not ask him what his pain level was and would just give him his pain pills when he could have them. Resident #49 said his pain medicine was last changed when he had a wound on his left leg in May 2024, but he said the wound was completely healed now. Resident #49 said he had complained of pain so much that he felt he was annoying the nursing staff.</p> <p>Resident #49 and his partner were interviewed together on 7/19/24 at 9:49 a.m. Resident #49 said he barely slept last night (7/18/24) because his phantom pain was shooting down his leg which kept him awake. Resident #49's partner said she felt Resident #49's pain had never been controlled by the facility despite several inquiries regarding his pain. Resident #49 and his partner said they were concerned the facility was not doing enough to manage Resident #49's pain.</p> <p>Resident #49 was interviewed again on 7/22/24 at 10:02 a.m. Resident #49 said he slept for a few hours between 6:00 a.m. and 8:00 a.m. this morning (7/22/24). Resident #49 said the pain in his right leg and hands prevented him from sleeping more the previous night. Resident #49 said he received his pain medication as scheduled but it did not relieve his pain. Resident #49 said his pain was constant.</p> <p>Resident #49 was interviewed again on 7/23/24 at 2:48 p.m. Resident #49 said he tried walking with his prosthetic leg today (7/23/24) but it caused so much pain in his leg he had to stop. Resident #49 said he was disappointed he could not walk or work to achieve his goals of walking more because of his pain today. He said he did not receive additional pain medication or non-pharmacological interventions to help him with the pain and he chose to stop walking instead.</p> <p>C. Record review</p> <p>The pain care plan, created and revised on 10/18/23, documented the resident had pain related to his right leg amputation below the knee. Interventions included administering analgesia (pain medication) as ordered, evaluating the effectiveness of the pain interventions, monitoring and documenting the cause of each pain episode, monitoring and documenting the side effects of pain medication, monitoring, recording and reporting to the nurse complaints of pain or requests for pain medication and offering non-pharmacological interventions for pain prior to administering medications.</p> <p>-The care plan did not identify Resident #49's pain in his hands (see pain assessment documentation below).</p> <p>-The care plan failed to include specific person-centered non-pharmacological interventions.</p> <p>The 10/17/23 pain assessment documented the resident had a hot or burning pain in the right knee, phantom pain in the right foot and pain in the sacrum. The assessment documented Resident #49 stated his pain caused him to be withdrawn from his relationships, made him withdrawn from activities, caused a decrease in physical activity, caused a loss of appetite and caused an inability to perform ADL's. Resident #49 stated that his pain prevented him from doing anything during the assessment. The assessment documented the resident's acceptable level of pain was a 2 out of 10.</p> <p>The 11/20/23 pain assessment documented the resident had a sharp, stabbing, and throbbing pain in the front of the right knee. The assessment documented the resident's acceptable level of pain was a 2 out of 10.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The pain assessment documented Resident #49's acceptable level of pain was a 2 out of 10, however, the physician's order to check the resident's pain level every shift documented the resident's acceptable level of pain was a 7 out of 10 (see physician's orders below).</p> <p>The 2/20/24 pain evaluation documented Resident #49 had a constant aching, throbbing, and tingling pain in the right knee, the left lower leg, the sacrum, and generalized aches and pains. The assessment documented the pain was worse in the evening and at night. The assessment documented the resident's acceptable level of pain was a 4 out of 10. The assessment documented that Resident #49's pain caused a decrease in physical activity, caused an inability to perform ADL's, affected Resident #49's ability to focus, and caused changes in Resident #49's mood and emotions.</p> <p>-The pain assessment documented Resident #49's acceptable level of pain was a 4 out of 10, however, the physician's order to check the resident's pain level every shift documented the resident's acceptable level of pain was a 7 out of 10 (see physician's orders below).</p> <p>The 5/20/24 pain evaluation documented Resident #49 had an aching and sharp phantom pain in his right knee, and generalized aches and pains. The evaluation documented the resident's acceptable level of pain was a 4 out of 10 on a numerical pain scale. The assessment documented that Resident #49's pain caused a decrease in physical activity, caused an inability to perform ADL's, affected Resident #49's ability to focus, and caused changes in Resident #49's mood and emotions. The assessment summary documented that pain was present and a management plan was needed, and to see the care plan for specifics.</p> <p>-However, the pain care plan was not updated after 10/18/23 (see care plan above).</p> <p>-The pain assessment documented Resident #49's acceptable level of pain was a 4 out of 10, however, the physician's order to check the resident's pain level every shift documented the resident's acceptable level of pain was a 7 out of 10 (see physician's orders below).</p> <p>The July 2024 CPO revealed the following physician's orders for pain management:</p> <p>Pain check every shift using PAINAD (pain assessment in advanced dementia) scale. Resident's acceptable level of pain is a 7, ordered on 11/20/23.</p> <p>-However, the pain assessments on 10/17/23, 11/20/23, 2/20/24 and 5/20/24 documented Resident #49's acceptable level of pain was a 2 or a 4 out of 10 (see pain assessments above).</p> <p>-The physician's order recommended using a pain evaluation for cognitively impaired residents, which was based on staff assessment. However, Resident #49 was cognitively intact and was able to state his pain level when asked.</p> <p>Oxycodone-acetaminophen oral tablet 5-325 milligrams (mg). Give one tablet by mouth three times a day for 8:00 a.m., 12:00 p.m., 8:00 p.m. and two tablets at 12:00 a.m., ordered on 5/30/24.</p> <p>A review of the medication administration record (MAR) from May 2024 to July 2024 revealed Resident #49 was documented to have received an oxycodone-acetaminophen oral tablet on 52 consecutive days at 5:00 p.m. between 5/31/24 and 7/21/24.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-However, the physician's order specified the resident was to receive the medication at 8:00 p.m., not 5:00 p.m.</p> <p>-The MAR from May 2024, June 2024, and July 2024 failed to document non-pharmacological interventions used to address Resident #49's pain.</p> <p>A review of pain assessment documentation on the MAR revealed that Resident #49's pain was assessed using the PAINAD scale a total of 105 times between 5/30/24 and 7/21/24. Of those 105 assessments, Resident #49 was documented to be experiencing pain above a 4 out of 10 on 71 of those pain assessments.</p> <p>-A review of Resident #49's EMR revealed there was no documentation to indicate the physician was notified or the facility addressed the resident's pain when his pain level was above his stated tolerable level of pain.</p> <p>IV. Staff interviews</p> <p>LPN #5 was interviewed on 7/22/24 at 4:48 p.m. LPN #5 said she had not assessed Resident #49's pain before obtaining his pain medication from the medication cart. LPN #5 said the physician's order for oxycodone-acetaminophen 5-325 mg for Resident #49 was confusing. LPN #5 said when a physician's orders appeared confusing, nursing staff should clarify the order to ensure the medication was administered correctly. LPN #5 said she had not clarified Resident #49's pain medication order before 7/22/24 (during the survey).</p> <p>LPN #2 was interviewed on 7/22/24 at 4:49 p.m. LPN #2 said she had always given Resident #49 his pain medication at 5:00 p.m. because the MAR had pain medicine scheduled for 5:00 p.m. LPN #2 said she re-read the order and was unsure if the pain medication could be given at 5:00 p.m. LPN #2 said confusing physician's orders should be clarified with the provider.</p> <p>LPN #2 was interviewed again on 7/23/24 at 9:11 a.m. LPN #2 said Resident #49 always had pain whenever she assessed him for pain. LPN #2 said she did not know what Resident #49's acceptable pain level was. LPN #2 said Resident #49's pain medication was last reviewed and updated in May 2024.</p> <p>Certified nurse aide (CNA) #7 was interviewed on 7/23/24 at 9:17 a.m. CNA #7 said Resident #49 frequently complained of pain in his leg or his hands. CNA #7 said the facility managed Resident #49's pain with pain medications.</p> <p>CNA #8 was interviewed on 7/23/24 at 9:26 a.m. CNA #8 said Resident #49 complained of pain every day. CNA #8 said the nursing staff had known about Resident #49's pain for a long time. CNA #8 said the facility used pain medications to help Resident #49's pain, but she was unsure how well the pain medications were working for the resident's pain.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The DON was interviewed on 7/22/24 at 4:51 p.m. The DON said the physician's order for oxycodone-acetaminophen 5-325 mg for Resident #49 was confusing. The DON said the ordering provider had clicked a scheduling button to schedule a dose at 5:00 p.m. when the provider entered the order into the facility's electronic medical record system. She said this prompted the order to be scheduled at 5:00 p.m. on the MAR instead of at 8:00 p.m. as was documented in the physician's order. The DON said the order was correct but should be clarified with the provider. The DON said she would call the ordering provider and change the medication order to be more easily understood by the nursing staff.</p> <p>-However, the nursing staff was administering Resident #49's pain medication at 5:00 p.m. instead of 8:00 p.m. which was the time specified in the physician's order (see record review above).</p> <p>The DON and corporate consultant (CC) #2 were interviewed together on 7/23/24 at 4:53 p.m. The DON said it was normal for the facility to assess pain on admission, quarterly and whenever a resident experienced a change in condition. The DON said she was not aware Resident #49 was having uncontrolled pain.</p> <p>The DON said she was not concerned about documented discrepancies regarding Resident #49's acceptable pain level because Resident #49 had not alerted staff that he was having uncontrolled pain.</p> <p>CC #2 said the ordering provider had entered Resident #49's pain order incorrectly but the order had been corrected to reflect the appropriately scheduled time of administration in the July 2024 CPO.</p>		

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48412</p> <p>Based on record review and interviews, the facility failed to complete a performance review of every nurse aide at least once every 12 months and provide regular in-service education based on the outcome of these reviews for four out of five staff reviewed.</p> <p>Specifically, the facility did not complete annual performance reviews and/or provided regular in-service education based on the outcome of the reviews for certified nurse aide (CNA) #2.</p> <p>Findings include:</p> <p>I. Record review</p> <p>CNA #2 (hired on 6/23/22) did not have an annual performance review completed. CNA #2 did not have an in-service education plan based on the outcome of the review.</p> <p>II. Staff interviews</p> <p>The director of staff development (DSD) was interviewed on 7/22/24 at 2:18 p.m. The DSD said she completed an audit of the system when she accepted her position in the beginning of 2024. She said she discovered there was an issue with staff completing their training as required. She said she worked on a spreadsheet to help track the training staff needed to complete. She said the staff completed a performance every year and if it was a good performance review, the staff received a raise. She said CNA #2 received a raise but she was unable to find their performance reviews.</p> <p>The nursing home administrator (NHA) was interviewed on 7/23/24 at 7:19 p.m. The NHA said if a CNA received an annual raise then an annual performance review was completed.</p> <p>-However, the facility was unable to provide documentation indicating CNA #2 had received an annual performance review.</p> <p>III. Facility follow-up</p> <p>On 7/26/24 at 12:44 p.m. the NHA said CNA #2 received a raise for the [AGE] year but she was unable to find her performance review.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>48412</p> <p>Based on observations, record review and interviews, the facility failed to consistently serve food that was palatable, attractive and at the appropriate temperature.</p> <p>Specifically, the facility failed to ensure food was palatable and attractive when delivered to residents.</p> <p>Findings include:</p> <p>I. Resident interviews</p> <p>Resident #65 was interviewed on 7/17/24 at 11:54 a.m. Resident #65 said when he received his breakfast in his room it was always served cold and under seasoned.</p> <p>Resident #49 was interviewed on 7/18/24 at 8:40 a.m. Resident #49 said the food was bland and had no taste. He said he received cold food.</p> <p>Resident #13 was interviewed on 7/18/24 at 10:34 a.m. Resident #13 said breakfast was always served cold. She said she was the last resident to get her tray.</p> <p>Resident #28 was interviewed on 7/18/24 at 11:56 a.m. Resident #28 said the food tasted awful and the meals were frequently served cold. Resident #28 said he had received undercooked chicken so he ordered something different if chicken was being served.</p> <p>II. Resident group interview</p> <p>Four residents (#65, #16, #59 and #49), who were identified as interviewable by the facility and assessment, were interviewed on 7/22/24 at 9:30 a.m. Residents made the following comments:</p> <ul style="list-style-type: none"> -The vegetables were soggy or uncooked; -The meals were served cold; -Food items were switched out (received chips instead of french fries); -Food items were served burnt; and, -The meat was undercooked. <p>III. Test tray</p> <p>A test tray was evaluated by three surveyors on 7/22/24 at 12:29 p.m.</p> <p>The test tray consisted of cheesy ham and macaroni casserole, sauteed garlic and spinach, pineapple tidbits and a dinner roll.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The cheesy ham and macaroni casserole was dry, bland and did not have a cheese sauce mixed through it.</p> <p>- The spinach tasted plain and did not have garlic seasoning.</p> <p>IV. Food committee notes</p> <p>The food committee notes were provided by the nursing home administrator (NHA) on 7/22/24 at 4:00 p.m.</p> <p>The food committee notes from 5/7/24 revealed the kitchen was still working on proper food temperatures and appealing plating.</p> <p>The food committee notes from 6/4/24 revealed the kitchen was still working on proper food temperatures and appealing plating.</p> <p>The food committee notes from 7/16/24 revealed the kitchen was working on ensuring food was properly cooked before it was served and getting the meals out on time and promptly.</p> <p>V. Staff interviews</p> <p>The cook (CK) was interviewed on 7/22/24 at 11:30 a.m. The CK said he seasoned the meals based on what the recipe indicated.</p> <p>The dietary manager (DM) and the dietary consultant (DC) were interviewed together on 7/23/24 at 10:15 a.m. The DM said she and the DC were worried about the pineapple not being on ice during the meal service and had placed the last tray of pineapple in the refrigerator to try to cool it down before the last half of the residents were served.</p> <p>The DC said the CK was supposed to put poultry gravy over the top of the casserole for all residents who were on a dysphagia altered diet. The DC said the cheesy ham casserole was dry and bland because the CK was adding poultry gravy to the casserole for the residents but failed to add it to the test tray. She said the CK was worried about how the gravy tasted on top of macaroni and cheese and omitted it from the test tray. The DC said she was going to review the recipes. She said she would let the kitchen staff know if the recipe indicated to provide a sauce, it needed to match the menu item and not just a form of gravy. She said the CK should have provided a cheese sauce to the residents on a dysphagia diet and the test tray, instead of gravy, since it was a macaroni and cheese type of casserole.</p> <p>The DM said she tried to follow-up on the residents' concerns in food committee meetings but she had a budget she had to stay under and she tried her best to please the residents while not going over the budget.</p> <p>The DC said the DM needed to make sure the residents were happy and not focus on the budget as much. The DC said she was going to work with the DM to fix the concerns in the kitchen.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>48412</p> <p>Based on observations, record review and interviews, the facility failed to store, prepare, distribute and serve food in a sanitary manner in the main kitchen and two of two kitchenettes.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> -Ensure residents were offered and provided hand hygiene before meals; -Ensure the kitchen staff appropriately cleaned thermometers before temperatures were obtained from ready-to-eat foods; and, -Ensure cold foods were held at 41 degrees Fahrenheit (F) or below before serving residents. <p>Findings include:</p> <p>I. Resident hand hygiene</p> <p>A. Facility policy and procedure</p> <p>The Handwashing and Hand Hygiene policy, revised August 2019, was provided by the nursing home administrator (NHA) on 7/23/24 at 5:15 p.m. It documented in pertinent part,</p> <p>All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections.</p> <p>All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors.</p> <p>Wash hands with soap and water when hands are visibly soiled.</p> <p>Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap and water for the following situations: before and after direct contact with residents, and before and after eating or handling food.</p> <p>B. Observations</p> <p>On 7/17/24 during a continuous observation, beginning at 11:49 a.m. and ending at 12:58 p.m., the following was observed in the main dining room:</p> <p>At 11:55 a.m. Resident #5 was observed self-propelling herself in the dining room. The resident shook the hands of Resident #27 and Resident #70. After shaking hands, Resident #5 then self-propelled herself to a dining table.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>At 12:08 p.m., Resident #5 was served her lunch plate by staff, which included peas, a dinner roll, meatloaf, mashed potatoes and an ice cream cup.</p> <p>-The resident was not offered hand hygiene by staff members.</p> <p>At 12:10 p.m., Resident #5 began eating her lunch plate. Resident #5 used her fingers to scoop the ice cream out of the ice cream cup and then eat the ice cream. The resident frequently licked her fingers between bites of the ice cream she was scooping out with her fingers. After finishing her ice cream with her hands, she began picking up pieces of meatloaf, peas and mashed potatoes with her hands. The resident continued to lick her fingers between small scooping bites which she ate with her fingers. The resident had been provided with tableware but did not attempt to use it.</p> <p>At 12:15 p.m., Resident #70 began eating his dinner roll with his hands.</p> <p>-Resident #70 had not been offered hand hygiene after he shook hands with Resident #5.</p> <p>At 12:19 p.m., Resident #27 began eating his dinner roll with his hands.</p> <p>-Resident #27 had not been offered hand hygiene after he shook hands with Resident #5.</p> <p>At 12:36, Resident #5 finished eating. After licking her fingers, she self propelled herself in her wheelchair and shook hands with Resident #27. After shaking hands with Resident #27, Resident #5 self-propelled herself out of the dining room.</p> <p>-The facility failed to offer hand hygiene to Resident #5 before or after meals.</p> <p>-The facility failed to offer hand hygiene to Resident #27 or Resident #70 when their hands became contaminated.</p> <p>C. Resident interviews</p> <p>Resident #16 was interviewed on 7/18/24 at 10:31 a.m. Resident #16 said the facility did not offer hand hygiene before or after meals in the main dining room. Resident #16 said the facility used to have hand sanitizer on dining room tables but one resident ate the hand sanitizer and there had not been hand sanitizer available in the dining room for residents since that incident.</p> <p>Resident #27 was interviewed on 7/18/24 at 11:13 a.m. Resident #27 said the facility sometimes offered hand hygiene before meals but it was not done consistently. Resident #27 said he would like to be able to clean his own hands when he wanted to during meals but he said he would have to either leave his table or bother the busy staff to do so.</p> <p>D. Staff interviews</p> <p>The dietary manager (DM) was interviewed on 7/23/24 at 10:15 a.m. The DM said it was the nursing staff's responsibility to provide the residents with hand hygiene at meals.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The infection preventionist (IP) and the director of nursing (DON) were interviewed together on 7/23/24 at 1:58 p.m. The IP said all residents should be offered hand hygiene before and after all meals. The IP said the dining room staff should offer hand hygiene to residents that were eating with their hands. The DON said she was not aware of any concerns with hand hygiene of residents in the dining room.</p> <p>II. Improper cleaning of food thermometer</p> <p>A. Professional reference</p> <p>The Colorado Department of Public Health and Environment (2024) The Colorado Retail Food Establishment Rules and Regulations, retrieved on 7/28/24 from https://drive.google.com/file/d/1kEtv4f6YciFXXzLEu6amUc9Anu9uWGYn/view, revealed in pertinent part, Equipment food-contact surfaces and utensils shall be clean to sight and touch.</p> <p>Utensils shall be cleaned before using or storing food temperature measuring devices.</p> <p>B. Lunch observations on 7/22/24 at 11:30 a.m.</p> <p>The cook (CK) grabbed five thermometers to obtain the temperatures of lunch before service began. The CK uncovered one thermometer and immediately placed it in the pureed spinach. The CK uncovered the second thermometer and immediately placed it in the pureed cheesy ham and macaroni casserole. The CK uncovered the third thermometer and immediately placed it in the dinner rolls. The CK uncovered the fourth thermometer and immediately placed it in the vegetable soup. The CK uncovered the fifth thermometer and immediately placed it in the mashed potatoes.</p> <p>-The CK did not sanitize any of the thermometers prior to putting them into the food to obtain the temperatures.</p> <p>C. Staff interviews</p> <p>The CK was interviewed on 7/22/24 at 11:45 a.m. CK said he assumed the thermometers were disinfected from the last time the thermometers were used. The CK said the thermometers appeared clean.</p> <p>The DM and the dietary consultant (DC) were interviewed together on 7/23/24 at 10:15 a.m. The DM said the staff were to gather the thermometers, temperature recording log and alcohol wipes. She said the staff needed to use an alcohol wipe to clean the thermometer when the cover was removed because staff should not assume the thermometers were clean. The DM said she disinfected the thermometers after the CK took the initial temperatures but failed to see he did not disinfect the thermometers prior to use.</p> <p>The DC said the CK should have sanitized each thermometer before he placed the thermometers in the food and it was unacceptable to assume the thermometers were already sanitized.</p> <p>III. Correct cold food holding temperatures</p> <p>A. Professional reference</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The Colorado Department of Public Health and Environment (2024) The Colorado Retail Food Establishment Rules and Regulations, retrieved on 7/28/24 from https://drive.google.com/file/d/1kEtv4f6YciFXXzLEu6amUc9Anu9uWGYn/views, read in pertinent part, Except during preparation, cooking, or cooling, or when time is used as the public health control time and temperature control for safety food shall be maintained at 41 degrees Fahrenheit (F) or less.</p> <p>The FDA (Food and Drug Administration) food code (3/27/23) was retrieved on 7/28/24 from https://www.fda.gov/food/fda-food-code/food-code-2022. It read in pertinent part, Bacterial growth and/or toxin production can occur if time/temperature control for safety food remains in the temperature danger zone (41 degrees to 135 degrees F) too long.</p> <p>B. Observations</p> <p>On 7/22/24 at 11:30 a.m., the CK obtained the temperature of the two trays of individually portioned pineapple sitting on the counter near the serving line. He said one tray was 45 degrees F and the other tray was 42 degrees F.</p> <p>C. Test tray</p> <p>A test tray was evaluated by three surveyors on 7/22/24 at 12:29 p.m. The test tray consisted of cheesy ham and macaroni casserole, sauteed garlic and spinach, pineapple tidbits and a dinner roll.</p> <p>-The temperature of the pineapple was 47.5 degrees F.</p> <p>D. Staff interviews</p> <p>The CK was interviewed on 7/22/24 at 11:30 a.m. The CK said he preferred the temperature of cold items to be below 39 degrees F but the pineapple was okay to be served at the temperatures he got.</p> <p>The DM and the DC were interviewed together on 7/23/24 at 10:15 a.m. The DM said she was concerned about the pineapple not being on ice while lunch was served.</p> <p>The DC said she moved the last tray of pineapple to the refrigerator until it was needed for lunch. The DC said she hoped it would keep the pineapple cold and at the proper temperature. The DC said the trays the pineapple was on should have had ice under them to keep the pineapple at the correct temperature.</p>		

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<p>F 0847</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse.</p> <p>40467</p> <p>Based on record review and interviews, the facility failed to ensure the facility's binding arbitration agreement was thoroughly and accurately explained to the residents and or resident representatives before signing the agreement for two (#176 and #40) of three residents out of 41 sample residents.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> -Thoroughly explain the binding arbitration agreement in a form and in a manner to ensure Resident #176 and Resident #40 and/or their representatives understood the agreement before signing the arbitration agreement; and, -Ensure staff reviewing the arbitration agreement with Resident #176 and Resident #40 and/or their representatives understood the components of the agreement. <p>Findings include:</p> <p>I. The Arbitration Agreement</p> <p>The Arbitration Introduction form, undated, was provided by the nursing home administrator (NHA) on 7/22/24 at 2:51 p.m. The Arbitration Introduction read in pertinent part,</p> <p>Arbitration is a cost effective, private and time saving alternative means of resolving disputes outside of the courts. In arbitration, disputes are heard and decided by a private individual called an arbitrator. the disputes will not be heard or decided by a judge or jury under any circumstances.</p> <p>The decision of the arbitrator is binding on both parties and any judgment on an award can be enforced by court if necessary. there is no appeal of an arbitrator's decision, so disputes can be resolved efficiently and timely.</p> <p>The Arbitration Agreement form, dated 2019, was provided by the NHA on 7/22/24 at 2:51 p.m. The agreement read in part:</p> <p>The parties agree that any legal dispute, controversy, demand or claim shall be resolved exclusively by binding arbitration administered by (an entity that assists with arbitration, mediation and other alternative dispute resolutions with facilities throughout the United States; contact information by a single neutral arbitrator agreed upon the parties and not by a lawsuit or resort to court processes, except to the extent that's applicable by state and federal law providing judicial review of arbitration proceedings or judicial enforcement of arbitration agreements and awards.</p> <p>(continued on next page)</p>		

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<p>F 0847</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>This agreement and the claim or claims to which it applies includes, but is not limited to, those that arise out of or relate to the admissions agreement, any service or health care provided by us to you, violations of any right granted to you by law or by the admission is agreement that would constitute a cause of action in court of law and include, but not limited to, breach of contract or warranty, express or implied, fraud or misrepresentation, wrongful death, survival action, negligence, gross negligence, malpractice, any claim based on any departure from accepted standards of care for medical or other health care related services, healthcare or safety. This includes all claims whether sounding in tort, in contract or based on any claim of violation of any federal, state, local or other government law, statute, regulation, ordinance, or common law and including any consumer protection act. This agreement shall not limit your right to file a grievance or complaint, formal or informal, with us or any appropriate state or federal agency.</p> <p>It is the intention of the parties to this agreement that it shall inure to the benefit of and bind the parties, their successors and assigns, including our agents, employees, managers or owners, and all persons who claim is derived through, as a result of or on behalf of you including that of any parent, spouse, sibling, child, guardian, executor, personal representative, administrator, conservator, legal representative or heir.</p> <p>Both parties to this agreement, by entering into it, have agreed the use of binding arbitration in lieu of having any dispute decided in a court of law before a jury.</p> <p>By signing this agreement you are agreeing to have any issue of medical malpractice decided by neutral binding arbitration rather than a jury or court trial. you have the right to seek legal counsel and you have the right to rescind this agreement within 90 days from the date of signature by both parties unless this agreement was signed in contemplation of hospitalization in which case you have 90 days after discharge or release from the hospital to resend the agreement.</p> <p>II. Resident representative interview</p> <p>Resident #176's representative was interviewed on 7/22/24 at 3:45 p.m. The representative said she signed the arbitration agreement for Resident #176 but questioned the admissions coordinator (AC) about the court process. She said she told the AC, by signing the arbitration agreement, it looked like she could not sue the facility if there was ever any problem. She said she was told by the AC that a mediator would be used if there was a concern, but if mediation did not work to resolve the concern, she could still go to court. The representative said she declined a paper copy of the agreement but received it electronically. She said she had not reviewed it since she signed the agreement.</p> <p>III. Resident interview</p> <p>Resident #40 was interviewed on 7/22/24 at 5:58 p.m. Resident #40 said she signed everything the facility asked her to sign when she was admitted to the facility. She said she was not sure what she signed because could not see well enough to read it. She said she had a basic understanding of what arbitration was, and believed it was binding, but she was not told that she could not go to court if she wanted to after signing the agreement. Resident #40 said she had to rely on someone to tell her what all her paperwork read because of her impaired vision.</p> <p>IV. Record review</p> <p>(continued on next page)</p>		

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<p>F 0847</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Arbitration Agreement and Arbitration Introduction forms for Resident #40 and Resident #176 were provided by the NHA on 7/22/24 at 2:51 p.m.</p> <p>Resident #40 signed her own Arbitration Agreement and Arbitration Introduction forms. The Arbitration Agreement and Arbitration Introduction were signed by the AC as the staff representative.</p> <p>Resident #40's Arbitration Agreement and Arbitration Introduction forms were signed by Resident #40 on 7/2/24 at 4:37 p.m. The Arbitration Agreement and Arbitration Introduction forms were signed by the AC on 7/2/23.</p> <p>Resident #176's Arbitration Agreement and Arbitration Introduction forms were signed by Resident #176's representative on 5/22/24.</p> <p>-Resident #176's Arbitration Agreement and Arbitration Introduction forms were signed by the AC but the signature was not dated.</p> <p>V. Staff interviews</p> <p>The AC was interviewed on 7/18/24 at 5:06 p.m. The AC said she had been responsible for the facility's admissions paperwork since May 2024. She said the Arbitration Agreement and Arbitration Introduction forms were part of the admission packet. She said she would review the Arbitration Agreement and Arbitration Introduction forms with the resident if they were signing forms. She said if the resident's representative signed the Arbitration Agreement and Arbitration Introduction forms, she would review the forms with them in person or send the forms to them electronically to sign and return it to her. The AC said she explained to the resident and/or their representative that they had the right to have their disputes reviewed and decided by a third party. The AC said she would usually read the Arbitration Agreement and Arbitration Introduction forms to the resident or resident's representative if they signed in person. She said if the resident's representative was not able to come into the facility to sign the Arbitration Agreement and Arbitration Introduction forms with her in person, she would email the forms to them and have them sign the forms electronically. The AC said she was not sure if the arbitration agreement was binding. She said she would have to find out. She said she was not sure if or when the resident/representative could revoke the arbitration agreement.</p> <p>The AC said she did not receive training on the arbitration agreement or arbitration process. She said if she or families had questions, she could contact the corporate consultant (CC #2) or someone else. She said CC #2 used to be the facility's admissions coordinator.</p> <p>The NHA was interviewed on 7/22/24 at 3:56 p.m. The NHA said the AC reviewed all of the admissions paperwork with the resident/resident's representative, including the Arbitration Agreement and Arbitration Introduction forms. The NHA said the resident/resident representative had the option not to sign the forms. She said the AC should explain what an arbitration agreement was. She said the resident/representative could review the Arbitration Agreement and Arbitration Introduction forms with a lawyer. The NHA said from her understanding, the arbitration agreement was not binding and the resident/representative could still go to court. The NHA said she was not sure how long the resident/representative had to rescind the arbitration agreement after signing it.</p> <p>(continued on next page)</p>		

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<p>F 0847</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>CC #2 was interviewed on 7/23/24 at 10:24 a.m. CC #2 said she had been the facility's admissions coordinator off and on between October 2022 and March 2024. She said prior to the current AC, she would review the Arbitration Agreement and Arbitration Introduction forms with the resident/resident's representative if they signed the forms in person or she would email them the forms to them to sign and return to her.</p> <p>CC #2 said she would ask the resident/resident representative if they were familiar with what an arbitration agreement was and then touch on a few components of the agreement. She said she would tell them arbitration was the last step in the grievance/concern process. She said she would emphasize that the arbitration agreement could be canceled anytime within 30 days with written notice, and not signing the agreement would not affect the care and services provided at the facility. She said it was the resident/resident representative's choice to sign or not. CC #2 said the arbitration agreement was binding after 30 days. She said she did not reiterate if the resident/representative could still go to court after the 30 days. She said no one usually asked about it so she did not go over it.</p> <p>CC #2 said she would tell the resident/representative, arbitration was prior to other legal processes. CC #2 said she was not sure what the legal processes were after arbitration.</p> <p>CC #2 said most residents who signed the Arbitration Agreement and Arbitration Introduction forms did not want a copy, however, she said they were informed the Arbitration Agreement and Arbitration Introduction forms were available to them in their medical record.</p> <p>CC #2 said she reviewed and trained the current AC on the Arbitration Agreement and Arbitration Introduction forms but had since learned there were things the AC did not know regarding the arbitration agreement process. CC #2 said she was a facility resource and occasionally the AC would contact her with admissions questions.</p> <p>CC #1 was interviewed on 7/23/24 at 12:23 p.m. CC #1 said the arbitration agreement was not binding until the resident entered into the arbitration agreement and it could be revoked. She said she did not work much with arbitration and would need to get clarification from CC #2.</p> <p>CC #3 was interviewed on 7/23/24 at 1:25 p.m. CC #3 said the arbitration agreement needed to be in plain legal language and the resident/resident representative needed to acknowledge they understood the Arbitration Agreement and Arbitration Introduction forms. She said the arbitration agreement had to state the arbitration agreement could be revoked within 30 days but the facility's agreement would allow the resident/representative to revoke the arbitration agreement by 90 days. She said the arbitration agreement was binding after 90 days from the signing of the arbitration agreement. She said the whole point of the arbitration agreement was not to go to court if there was a dispute between the resident and the facility. CC #3 said, by signing the arbitration agreement, the resident/resident representative gave up the right to go to court. She said she hoped the facility was going over the arbitration process with the residents/representatives.</p> <p>The NHA was interviewed again on 7/23/24 at 1:36 p.m. The NHA said the facility would conduct an education with any staff involved or had the potential to be involved in the admissions process. She said the education would go over the components of the arbitration process. She said she would clarify the arbitration process with all residents and resident representatives who had signed the Arbitration Agreement and Arbitration Introduction forms since May 2024. She said she would contact the residents and their representatives before the 90 day deadline of signing the arbitration agreement.</p>		

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NAME OF PROVIDER OR SUPPLIER Canyon View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 151 E 3rd St Palisade, CO 81526	

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50314</p> <p>Based on observations, record review and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the possible development and transmission of infectious diseases.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> -Implement an effective water management plan; and, -Ensure housekeeping staff properly sanitized resident rooms. <p>Findings include:</p> <p>I. Failure to have an effective water management plan</p> <p>A. Professional reference</p> <p>According to The Center for Disease Control (CDC) Legionella (Legionnaires Disease and Pontiac fever) (3/25/21), retrieved on 7/10/24 from https://www.cdc.gov/legionella/wmp/toolkit/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Flegionella%2Fmaintenance%2Fwmp-toolkit.html and https://www.cdc.gov/legionella/wmp/overview.html,</p> <p>Many buildings need a water management program to reduce the risk for Legionella growing and spreading within their water system and devices.</p> <p>Legionella bacteria are typically found naturally in [NAME] environments, but can become a health concern when they grow and spread in human-made water systems. Legionella can cause a serious type of pneumonia (lung infection) known as Legionnaires disease. Some water systems in buildings have a higher risk for Legionella growth and spread than others. Legionella water management programs are now an industry standard for many buildings in the United States.</p> <p>Legionella bacteria can cause a serious type of pneumonia (lung infection) called Legionnaires disease. Legionella bacteria can also cause a less serious illness called Pontiac fever.</p> <p>The key to preventing Legionnaires disease is to reduce the risk of Legionella growth and spread. Building owners and managers can do this by maintaining building water systems and implementing controls for Legionella.</p> <p>Water management programs identify hazardous conditions and take steps to minimize the growth and transmission of Legionella and other waterborne pathogens in building water systems. Developing and maintaining a water management program is a multi-step process that requires continuous review.</p> <p>Seven key elements of a Legionella water management program are to:</p> <ul style="list-style-type: none"> -Establish a water management program team <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-Describe the building water systems using text and flow diagrams</p> <p>-Identify areas where Legionella could grow and spread</p> <p>-Decide where control measures should be applied and how to monitor them</p> <p>-Establish ways to intervene when control limits are not met</p> <p>-Make sure the program is running as designed (verification) and is effective (validation)</p> <p>-Document and communicate all the activities.</p> <p>Principles: In general, the principles of effective water management include:maintaining water temperatures outside the ideal range for Legionella growth; preventing water stagnation;ensuring adequate disinfection; and,maintaining devices to prevent sediment, scale, corrosion, and biofilm, all of which provide a habitat and nutrients for Legionella.</p> <p>Once established, water management programs require regular monitoring of key areas for potentially hazardous conditions and the use of predetermined responses to respond when control measures are not met.</p> <p>A consultant with Legionella-specific environmental expertise may sometimes be helpful in implementing and operating water management programs.</p> <p>According to the CDC's Controlling Legionella in Potable Water Systems, (2/3/21), retrieved on 7/10/24 from https://www.cdc.gov/control-legionella/media/pdfs/Control-Toolkit-Potable-Water.pdf,</p> <p>Store hot water at temperatures above 140 degrees fahrenheit (F) and ensure hot water in circulation does not fall below 120 degrees F. Recirculate hot water continuously, if possible.</p> <p>Store and circulate cold water at temperatures below the favorable range for Legionella (77 degrees F to 113 degrees F). Legionella may grow at temperatures as low as 68 degrees F.</p> <p>B. Facility policy and procedure</p> <p>The Legionella Water Management Program policy, revised September 2022, was obtained from the nursing home administrator (NHA) on 7/23/24 at 5:15 p.m. It documented in pertinent part,</p> <p>Our facility is committed to the prevention, detection and control of water-borne contaminants, including Legionella.</p> <p>As part of the infection prevention and control program, our facility has a water management program, which is overseen by the water management team.</p> <p>The water management team consists of at least the following personnel: the infection preventionist, the administrator, the medical director, the director of maintenance, and the director of environmental services.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The water management program used by our facility is based on the Centers for Disease Control and Prevention and ASHRAE (The American Society of Heating, Refrigeration, and Air Conditioning Engineers) recommendations for developing a Legionella water management program.</p> <p>The water management program includes the following elements:</p> <p>-An interdisciplinary water management team, a detailed description and diagram of the water system in the facility, the identification of areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria, the identification of situations that can lead to Legionella growth and specific measures used to control the introduction and/or spread of Legionella.</p> <p>B. Record review</p> <p>The facility's water management plan was provided by the director of maintenance services (DMS) on 7/23/24 at 11:01 a.m. The documentation included a copy of the CDC's recommendations for developing a Legionella water management program and a diagram of the building, without identifying water systems.</p> <p>-The facility failed to describe the building water systems using text and flow diagrams.</p> <p>-The facility failed to document when the water management program was initiated.</p> <p>-The facility failed to identify areas where Legionella could grow and spread.</p> <p>-The facility failed to decide where control measures should be applied and how to monitor them.</p> <p>-The facility failed to establish ways to intervene when control limits were not met.</p> <p>-The facility failed to make sure the program was running as designed and was effective.</p> <p>-The facility failed to document and communicate all the activities of the water management program.</p> <p>C. Staff interviews</p> <p>The DMS was interviewed on 7/23/24 at 1:24 p.m. The DMS said he checked some of the water systems regularly in the building but did not keep documentation of water system maintenance. He said he was not sure if he knew where all the water lines in the building were. The DMS said he was unsure if the facility had a diagram of all of the water lines in the building. He said he did not know if the facility had identified a method for ensuring the water management program was effective. The DMS said he had not read the water management program documentation that he had provided during the survey on 7/23/24 at 11:01 a.m.</p> <p>The NHA and the DON were interviewed together on 7/23/24 at 4:53 p.m. The NHA and the DON said they were unaware the facility did not have a water management program.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The NHA was interviewed again on 7/23/24 at 7:33 p.m. The NHA said she was not familiar with the details of what needed to be done concerning Legionella and Legionella prevention.</p> <p>II. Housekeeping failures</p> <p>A. Professional reference</p> <p>The CDC Environment Cleaning Procedures, (3/19/24) was retrieved on 7/25/24 from https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/appendix-c.html. It read in pertinent part,</p> <p>High-Touch Surfaces: The identification of high-touch surfaces and items in each patient care area is a necessary prerequisite to the development of cleaning procedures, as these will often differ by room, ward and facility.</p> <p>Common high-touch surfaces include: bed rails, IV (intravenous) poles, sink handles, bedside tables, counters, edges of privacy curtains, patient monitoring equipment (keyboards, control panels), call bells and door knobs.</p> <p>Proceed from cleaner to dirtier areas to avoid spreading dirt and microorganisms. Examples include: during terminal cleaning, clean low-touch surfaces before high-touch surfaces, clean patient areas (patient zones) before patient toilets, within a specified patient room, terminal cleaning should start with shared equipment and common surfaces, then proceed to surfaces and items touched during patient care that are outside of the patient zone, and finally to surfaces and items directly touched by the patient inside the patient zone. In other words, high-touch surfaces outside the patient zone should be cleaned before the high-touch surfaces inside the patient zone and clean general patient areas not under transmission-based precautions before those areas under transmission-based precautions.</p> <p>B. Observations</p> <p>On 7/22/24 at 1:04 p.m. housekeeper (HSKP) #1 was observed cleaning room [ROOM NUMBER].</p> <p>-The call light cords in the resident's room and the resident's bathroom were not cleaned by HSKP #1 during the room cleaning process.</p> <p>On 7/23/24 at 10:36 a.m. HSKP #2 was observed cleaning room [ROOM NUMBER].</p> <p>-The call light cords in the resident's room and the resident's bathroom were not cleaned by HSKP #1 during the room cleaning process.</p> <p>C. Record review</p> <p>Housekeeping in-service documentation, not dated, was obtained from corporate consultant (CC) #4 on 7/23/24 at 5:15 p.m. It documented the five step daily patient room cleaning procedure included emptying trash, disinfecting horizontal surfaces, spot cleaning walls, dust mopping the floor, and damp mopping the floor. It documented the seven-step washroom cleaning process included checking supplies, emptying trash, dust mopping the floor, cleaning and sanitizing the sink and tub, cleaning and sanitizing the toilet, spot cleaning walls and/or partitions, and damp mopping the floor.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40467</p> <p>Based on observations, record review and interviews, the facility failed to maintain an environment for residents, staff and the public that is safe, functional, sanitary and comfortable.</p> <p>Specifically, the facility failed to ensure appropriate communication occurred regarding the facility's [AGE] year old hot water heater. The facility's failure to address the concerns timely resulted in the hot water heater failing and the facility was without hot water to provide a comfortable bathing experience for residents during a three week time period.</p> <p>Finding include:</p> <p>I. Facility policy and procedure</p> <p>The Promoting/Maintaining Resident Dignity policy, dated 1/1/23, was obtained from the nursing home administrator (NHA) on 7/23/24 at 5:15 p.m. It documented in pertinent part,</p> <p>All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights.</p> <p>The resident's former lifestyle and personal choices will be considered when providing care and services to meet the resident's needs and preferences.</p> <p>II. Group resident interview</p> <p>Four residents (#16, #49, #59 and #65), who were identified as interviewable by the facility and assessment, were interviewed on 7/22/24 at 9:30 a.m. The following comments were made regarding the lack of hot water:</p> <p>-A resident said the facility had a hard time the first couple of days without hot water. The staff was not sure how to meet all the hot water needs when the hot water heater went down. The facility purchased basins to help with bathing. The staff would fill the basins with hot and cold water.</p> <p>-A resident said she normally had two showers a week. She said it would have been nice to have a shower but gave herself a sponge bath. She said it was hard to scrub her own back. She said the staff would offer to give her a bed bath at times.</p> <p>-A resident said she was worried that the lack of hot water would affect her personal hygiene and health. She said her skin had itched because she had not felt clean.</p> <p>-A resident said the staff would offer bed baths sometimes during the time the hot water heater was out and he would wash himself in the private areas but it was difficult. He said he felt the facility could have done more to make sure there was hot water for the showers. He said he was used to two showers a week and did not feel completely clean when he could not shower.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>III. Additional resident interviews</p> <p>Resident #16 was interviewed on 7/18/24 at 10:31 a.m. Resident #16 said the hot water went out for three or four weeks. Resident #16 said she was not able to shower during that time, and her wound care had to be provided differently than normal. Resident #16 said the lack of hot water made her feel like she wasn't getting cleaned as well or as often. Resident #16 said most residents hated the bed bath alternative that was offered during the three week period, but she said the only other choice was a cold shower. Resident #16 said she had not felt comfortable without hot water since that was a basic necessity of everyday life.</p> <p>Resident #65 was interviewed on 7/18/24 at 2:39 p.m. Resident #65 said he did not like either of the alternative bathing options presented so he chose to shower in cold water when the facility did not have hot water. Resident #65 said that showering with cold water day after day was an aggravating experience for him.</p> <p>Resident #59 was interviewed on 7/18/24 at 2:50 p.m. Resident #59 said when the hot water went out, many residents were not offered showers as often as they preferred. Resident #59 said she was offered alternative shower options but only once per week. Resident #59 said she preferred to shower three times per week. Resident #59 said she felt dirty and upset when the hot water was out and the bathing experience offered was uncomfortable for her. Resident #59 said she felt she had no other choice.</p> <p>Resident #10 was interviewed on 7/23/24 at 2:54 p.m. Resident #10 said the hot water was out for about three or four weeks in the facility and no one could take a hot shower. Resident #10 said she was not offered showers per her normal preference without the hot water. Resident #10 said she hated the bed bath option with water heated from the kitchen, but she would have tried that if she had ever been offered that option from staff. Resident #10 said she felt like any facility should have hot water and not being able to access warm water when she needed to had been very frustrating.</p> <p>Resident #40 was interviewed on 7/23/24 at 3:12 p.m. Resident #40 said she was never offered a bath in the period when the facility was without hot water. Resident #40 said she had wanted a normal hot shower like any facility should have and she just didn't want to take a cold shower. Resident #40 said she felt the bed bath option was demeaning for residents who normally showered themselves.</p> <p>IV. A frequent visitor (FV) was interviewed on 7/17/24 at 9:16 a.m. The FV said there was no hot water in the facility for resident showers for over three weeks between May 2024 and June 2024. She said there was a significant odor in the facility during that period of time.</p> <p>V. Resident council minutes</p> <p>The 5/28/24 resident council minutes documented the NHA said she would contact the facility's corporation on the afternoon of 5/28/24 to discuss the water heater and then would inform the residents on the water status when she knew more.</p> <p>The 6/24/24 resident council minutes documented the hot water heater has been fixed.</p> <p>VI. Record Review</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>A 5/13/24 impromptu QAPI meeting agenda/summary form was provided by CC #4 on 7/18/24 at 5:30 p.m. The summary form read the form was to be used between meetings to address an opportunity for improvement which required immediate response. According to the summary, the opportunity for improvement was a malfunction of the singular hot water heater that provided hot water to the entire building. The form identified the facility's response/plan:</p> <ul style="list-style-type: none"> -The HVAC vendor attempted to repair the hot water heater on 5/12/24. It was determined to be nonrepairable. -Ensure adequate paper products for the meals. -Ensure adequate bath packets for all residents three times a week for three weeks. -Notify residents and their families. -5/12/24 notification of the company and landlord. -Completion of a provided proposal for replacement on 5/13/24. -Educate staff on hand hygiene, bed baths and temperature safety. -Kitchen hot water and sanitation education. -Kitchen hot water and sanitation log. <p>The 5/10/24 HVAC vendor invoice was provided by the DMS on 7/22/24 at 1:40 p.m. The invoice identified the water heater was inspected, repairs were made and the counter steamer transformer was replaced. The invoice read the water heater was not firing and water was leaking from the heat exchanger tubes, which was a sign that the water heater was going bad.</p> <p>The 5/12/24 HVAC vendor invoice was provided by the DMS on 7/22/24 at 1:40 p.m. The invoice read the water heater was not lighting. According to the invoice, the vendor was contacted on 5/12/24 due to the water heater not operating. The vendor arrived at the facility and observed water from the water heater was leaking onto the burners and water was leaking from the tubes of the heat exchanger. After multiple attempts to light and repair the hot water heater it was determined it was no longer safe for use and needed to be replaced.</p> <p>An undated HVAC vendor invoice was provided by the DMS on 7/22/24 at 1:40 p.m. The invoice read the vendor received a monetary deposit on 5/30/24 and ordered the water heaters on 5/30/24. The water heaters would be delivered from two separate supply distributors. The estimated arrival delivery date of the water heaters was on 6/4/24. The demolition of the old water heater system was started on 6/4/24. The first water heater arrived on 6/4/24 and was installed and identified as in normal operation condition.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>According to the invoice, the original freight company that was scheduled to deliver the remaining water heaters was not available to deliver as scheduled. The HVAC vendor company offered to pick up the water heaters and deliver them to the facility on [DATE]. Installation was started and completed between 6/7/24 and 6/10/24. The invoice read, on 6/10/24, all three water heaters were in normal operating condition.</p> <p>A 5/31/24 mandatory manual wash in-service was provided by CC #4 on 7/18/24 at 5:30 p.m. The attendance for the in-service was signed by 12 staff members between 5/31/24 and 6/7/24. The inservice reviewed the policy and procedure to manually wash and sanitize all cookware, silverware and serviceware that was not processed through the dish machine.</p> <p>The 6/10/24 HVAC vendor service receipt was provided by the DMS on 7/22/24 at 1:40 p.m. The receipt read the failure of one water heater should no longer affect the hot water supply to the facility.</p> <p>The June 2024 quality assurance and performance improvement (QAPI) meeting minutes were provided by the NHA on 7/23/24 at approximately 9:15 a.m. The QAPI minutes documented the following in pertinent part: Hot water heater stopped working on 5/12/24. Final repairs completed on.</p> <p>-The QAPI minutes did not include the date the final repairs were completed.</p> <p>-The QAPI minutes did not include additional review of the lack of hot water facility response or revisions made to the facility ' s emergency plan.</p> <p>VII. Staff interviews</p> <p>The director of maintenance services (DMS) was interviewed on 7/18/24 at 1:52 p.m. The DMS said on 5/12/24 the hot water heater broke. He said he contacted the NHA and the regional consultant. He said he contacted a heating, ventilation and air conditioning (HVAC) service vendor and attempts were made to repair the hot water heater but it was determined the hot water heater was not repairable. He said he and the NHA started a plan of correction. He said the facility started boiling water from the kitchen, bed bath kits were ordered and hot water was collected from the hot and cold water drink dispensing towers. He said the kitchen started using paper products for meals.</p> <p>The DMS said the facility corporation was contacted and told it was an emergency. The corporation requested bids for a new water heater and repairs. The DMS said the facility's landlord and stakeholder had to also approve of the process. The DMS said, overall, the whole process went well and the residents seemed accepting of the changes and complained very little.</p> <p>The DMS said he did not believe the facility had a hot water heater policy to outline the procedures of what to do if the facility did not have hot water readily available. He said before the hot water heater broke, the facility did not have a back up plan. The DMS said the facility now had a three water heater system so if one went out, the other water heaters would still be able to provide the facility with hot water. He said each of the new hot water heaters were 100 gallons each.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Canyon View Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 151 E 3rd St Palisade, CO 81526	
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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The DMS said the prior water heater was over [AGE] years old and was leaking before it stopped working. He said the HVAC vendor came out to service the heater and recommended the facility get a new water heater. The DMS said he informed the NHA and his regional consultant of the recommendations but he was not sure exactly when he informed them. He said he was told to do the best he could as long as the hot water heater was still working.</p> <p>The DMS said there were no follow up meetings after the new hot water heaters were installed. He said the facility did not review the event after the incident to put new procedures in place. He said the facility was still pulling everything together.</p> <p>Certified nurse aide (CNA) #7 was interviewed on 7/18/24 at 1:55 p.m. CNA #7 said the hot water was out for about almost a month in the facility in May 2024. CNA #7 said the facility had offered residents bed baths with water warmed from the kitchen, or prepackaged bathing cloths during that time period. CNA #7 said most residents did not like either alternative bathing option. CNA #7 said a lot of residents in the facility refused baths while the hot water was out.</p> <p>CNA #8 was interviewed on 7/18/24 at 2:01 p.m. CNA #8 said the facility did not have hot water for three or four weeks in May 2024. CNA #8 said the facility had offered residents prepackaged bathing cloths or bed baths during that time period. CNA #8 said many residents refused both alternative bathing options while the hot water was out.</p> <p>Licensed practical nurse (LPN) #1 was interviewed on 7/18/24 at 2:10 p.m. LPN #1 said the facility had offered residents prepackaged bathing cloths or a warm water basin bath as alternative bathing options while the hot water was out. LPN #1 said the residents who showered themselves independently were the most upset when the facility was without hot water.</p> <p>The director of nursing (DON) was interviewed on 7/18/24 at 2:29 p.m. The DON said when the hot water heater broke, her main focus was the residents' personal hygiene and sanitary conditions for preparation and service. She said wound care was not impacted by the lack of hot water. The DON said more disposable paper products were ordered for meal services. She said the facility ordered shower caps, more bed bath kits and water basins.</p> <p>The DON said the staff tried to offer bed baths on the same days the residents were usually scheduled for their showers. She said the residents were told they could also ask for bed baths and/or wipes if they felt they needed additional bathing opportunities. She said some residents were able to bathe at their family's homes. The DON said bathing wipes were warmed to help the residents feel more comfortable. She said the temperature of the hot water from the hot water drinking dispensers was taken and used for personal washing. She said the facility verbally informed the residents about the limited hot water and families were informed by letters. She said the lack of hot water from the hot water heater lasted for about three weeks, from May 2024 to June 2024. She said the facility now had three hot water heaters so if one water heater went down the facility would still have two working hot water heaters.</p> <p>The DON said staff expressed some frustration during the event. She said the bed baths took more staff time and there were more resident refusals than expected. The DON said many of the residents expressed understanding of the situation. She said once the hot water heaters were replaced, all residents were back to having their regular showers scheduled. She said everything was now back to normal.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The NHA was interviewed on 7/18/24 at 2:50 p.m. The NHA said when the DMS informed her of the broken hot water heater, she informed her corporate consultants and regional operation managers of the situation and started to put interventions in place. The NHA said on 5/13/24 she created a plan to review and identify needed supplies such as paper products, and bathing kits. She said she notified the residents of the situation and sent letters out by email to families.</p> <p>The NHA said she put together a three week plan because the HVAC vendor estimated it would take two to three weeks to have the water heater ordered and replaced. She said she discussed the costs with the corporation after getting quotes. The NHA said the facility had to decide on whether to have the hot water heater replaced quickly or take a little longer and get a better system that would include three water heaters so if one went down there would be a backup. She said by the end of the week of 5/13/24, the facility had decided to go with the three tank system. She said the hot water heaters needed to be ordered and transported from several miles away because there was nothing compatible in the area.</p> <p>The NHA said the HVAC vendor informed her that he would be able to do the labor within 24 to 48 hours of the delivery of the tanks. She said most of the delay for getting the hot water heater tank replaced was related to the release of the funds to the HVAC vendor so the tanks could be ordered. She said when the HVAC vendor received payment he ordered the tanks but the transportation company to deliver the tanks could only do part of the trip. She said the HVAC vendor had to find another company to transport the tanks the remainder of the way. The NHA said the tanks were delivered and installed on 6/4/24 and by 5:30 p.m. that day, the facility had running hot water throughout the facility with one domestic tank/heater operational. She said by 6/7/24, the other two tanks were installed and running. The NHA said the event was discussed in the June 2024 quality assurance and performance improvement (QAPI) meeting with the interdisciplinary team (IDT) (see record review above).</p> <p>Corporate consultant (CC) #4 was interviewed on 7/18/24 at 4:52 p.m. CC #4 said the facility did not have a lack of hot water policy and procedure. She said the closest the facility had was the plan created on 5/13/24, after it was determined the facility would be without hot water until the parts and repairs were in place.</p> <p>The DMS was interviewed again on 7/22/24 at 1:40 p.m. The DMS said he did not document his observations of the leaks with the hot water heater or communication of the leaks or invoices from the HVAC vendor when they came out to look at the leaks prior to May 2024.</p> <p>The HVAC service vendor was interviewed via telephone on 7/22/24 at 2:10 p.m. He said he was called out to the facility on [DATE] because the hot water heater was not firing up. He said the water was leaking from the heat exchanger tubes. He said he recommended replacing the water heater. The HVAC vendor said he replaced the burner assembly unit and transformer on 5/10/24.</p> <p>The HVAC vendor said he came out again on 5/12/24 when the hot water heater was not working again. He said water was leaking onto the burners and water was leaking from the heat exchanger. He said the water heater was shut off on 5/12/24 because it was no longer safe to run it.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The HVAC vendor said he was at the facility in January 2024 or February 2024. He said the expansion unit on the hot water heater had a hole in the unit, but the unit was not leaking at that time. He said, due to the price, the facility did not proceed with replacing the expansion tank. He said without a working expansion unit, he was not able to determine if there were additional problems with the system. The HVAC vendor said the facility had a separate tank that was working for domestic water. He said he did not have access to the invoices from January 2024 or February 2024 to determine the date when he came out to the facility because he was no longer working for that company.</p> <p>The HVAC vendor said he asked the facility if they had a policy for the hot water heater and he asked for one but never got an answer or the policy.</p> <p>The NHA and the DMS were interviewed together on 7/23/24 at approximately 9:15 a.m. The DMS said the facility did not have a safety meeting but plant operations were reviewed in QAPI. He said the review was mainly regarding fire drills or tabletop reviews of a potential emergency. He said the facility did not identify the lack of hot water if the hot water heater went out as a potential facility emergency, however he was concerned the hot water heater would go out in the middle of the night. He said the hot water heater was over [AGE] years old and there was some leaking and some corrosion on the old pipes. He said the system would shut itself off if there was a problem for safety.</p> <p>The DMS said, on 5/10/24, the hot water heater system would not light. The NHA was informed of the above interview with the hot water heater service vendor. The DMS said he also saw some leaking in April 2024 and had the vendor look at it, however, he said he had not informed the NHA that the hot water heater was leaking at that time. He said part of the system related to the copper coils boiler was disconnected to stop the leak. He said the facility had been operating with the one [AGE] year old hot water heater tank since April 2024. He said the one tank was due to be replaced. He said he did not think the corporation was aware that the facility had only one tank available that was [AGE] years old. The DMS said he did not record or document the past repairs, recommendations or observations to reference but he should have.</p> <p>The NHA said she was not aware that a new expansion tank was recommended by the vendor in January 2024 or February 2024.</p> <p>The NHA said during the hot water heater event, the residents were not in danger and basic needs were accommodated for. She said after the hot water heater event she learned that the facility needed to be more prepared with needed supplies, such as disposable paper products for food. She said the facility needed to make sure they had at least three days worth of supplies on site. She said the facility needed to have more bathing kits available in case of an emergency. She said the water heater event was an emergency.</p> <p>The NHA said, in retrospect, the facility could have benefited from an extra certified nursing assistant (CNA) on some of the busier days. She said staff did not complain a lot but she felt some of the staff needed more training on how to manage the situation with less frustration versus increasing the number of staff. She said she would like to have the staff go through additional training on crisis management. The NHA said nothing had been scheduled yet for the training and she needed to look at the training schedule to determine when it could be set up. She said she would reach out to CC #4 and other sister facilities to see if there were training materials available.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The NHA said to directly prevent the lack of hot water available, the new hot water system was purchased. The NHA said she did not have documentation that a post review of the hot water event was conducted or actions moving forward to prevent similar situations other than a reference in QAPI. She said she and the dietary manager verbally talked about the needed kitchen supplies and steps to take during the water heater event, but a procedure was not created and put in place after the water heater event to help mitigate future emergencies that involved the kitchen. The NHA said she would like to have three weeks for some supplies in the event of an emergency but had to see where there was enough space to stock the supplies. The NHA said reviewing the event following the incident on what the facility learned and what the next steps were to put in motion to help with future emergencies could use improvement.</p> <p>The NHA said the facility did not have a specific lack of hot water plan but it would be appropriate to have a policy in place. She said she would reach out to her corporate resources on how to create the policy and procedures. She said the policy would be implemented and added to the facility's emergency plan. The NHA said if the facility had a policy and procedure available, she would have added it with her plan as part of the facility's response and use it as additional guidance.</p> <p>50314</p>		