IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
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December 2, 2015

Rebecca Butler, Administrator
Prestige Care & Rehabilitation - The Orchards
1014 Burrell Avenue,
Lewiston, ID 83501-5589

Provider #: 135103

Dear Ms. Butler:

On **November 20, 2015**, a survey was conducted at Prestige Care & Rehabilitation - The Orchards by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE**: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 14, 2015**. Failure to submit an acceptable PoC by **December 14, 2015**, may result in the imposition of civil monetary penalties by **February 20, 2015**.

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

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;

- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and

- Include dates when corrective action will be completed in column (X5).

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

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **December 28, 2015 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **December 28, 2015**. A change in the seriousness of the deficiencies on **December 28, 2015**,

may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **December 28, 2015** includes the following:

Denial of payment for new admissions effective **February 20, 2016**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **May 19, 2016**, if substantial compliance is not achieved by that time.

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

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

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **November 20, 2015** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

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

- BFS Letters (06/30/11)

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

This request must be received by **December 14, 2015**. If your request for informal dispute resolution is received after **December 14, 2015**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,

David Scott, RN, Supervisor
Long Term Care

DJS/lj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135103		11/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESTIGE CARE & REHABILITATION - THE ORCHARDS	1014 BURRELL AVENUE LEWISTON, ID 83501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification survey conducted at the facility from November 16 to November 19, 2015. The surveyors conducting the survey were: Amy Barkley, RN, BSN, Team Coordinator Linda Hukill-Neil, RN Angela Morgan, RN, BSN Definitions include: cc - cubmic centimeters CSS - MAR - Medication Administration Record RCM - Resident Care Manager	F 000		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to ensure the standard nursing practices were followed in the care of residents' Peripheral Inserted Central Catheters [PICC]. This was true for 1 of 15 sampled residents (#10) and created the potential for harm from infection, clotting, or infiltration. Findings include: Resident #10 was admitted to the facility on 11/16/15 with multiple diagnoses including osteomyelitis.	F 281	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Prestige Care & Rehabilitation Center - The Orchards does not admit that the deficiencies listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiencies, statements, facts, and	12/24/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/11/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 281	Continued From page 1 The Lippincott Manual of Nursing Practice 9th edition (2010) by Lippincott, Williams and Wilkins, page 91, documented, "Check for swelling at the needle site when flushing." The Fundamentals of Nursing 8th edition (2013) by Potter & Perry page 611 documented, "Before administering an IV bolus ... assess the patency and placement of the IV site." The facility's "Nursing Policy and Procedure Use of Lippincott Manual" policy documented, "...the facility will utilize the most updated version of Lippincott to ensure clinical standards are being followed." The facility's Catheter Insertion and Care Policy, page 88, documented, "Insertion site assessment should be done as part of the flushing process to monitor for complications." On 11/18/15 at 12:30 PM, LN #3 was observed administering intravenous (IV) Vancomycin into the PICC line of Resident #10. The resident's right arm had a loose fitting stocking covering the insertion site of the PICC line. LN #3 removed the purple port of the PICC line from the stocking, wiped the port with an alcohol swab and, without assessing the insertion site, flushed the port with 12 cc of normal saline and then administered the Vancomycin. On 11/18/15 at 12:40 PM, LN #3 was asked if the insertion site should have been assessed prior to administering medication or flushing the PICC. LN #3 stated she viewed the site that morning before the resident left the facility. On 11/18/15 at 3:55 PM, the DON stated the PICC line should have been assessed prior to the administration of medication and flushes.	F 281	conclusions that form the basis for the deficiencies. F-281 Resident #10 is receiving care of his PICC Line in accordance with Standard Nursing Practice. Current residents with PICC lines have been reviewed and are receiving care in accordance with Standard Nursing Practice. Licensed Nurses (LN□s) have been re-educated on the Standard Nursing Practices for care of PICC Lines, by the Director of Nursing (DON) and/or designee. The Staff Development Coordinator (SDC) will perform random weekly performance evaluations of LN□s' care of PICC Lines x 1 month, then monthly x 2 months. Copies of performance evaluations will be forwarded to the DON for review and follow-up, as needed. The DON will track and trend the results of the performance evaluations and report findings to the Quality Assurance and Performance Improvement (QAPI) meeting monthly x 3 months to identify opportunities for performance improvement. The DON will ensure compliance. Date of Compliance □ 12/24/2015	

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F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and resident and staff interview, it was determined the facility failed to provide appropriate care to manage edema, wounds, and skin conditions for 2 of 15 (#s 4 & 8) sampled residents. The facility failed to ensure Resident #4 wore a "comperm" compression wrap covering a wound to one leg and a compression hose on the other leg for edema. The facility also failed to administer a medicated lotion to Resident #8 until 82 hours after it was ordered by the physician. The facility also did not notify the resident's physician that the medicated cream was not available. Findings include: 1. Resident #4 was admitted to the facility on 2/2/15 with multiple diagnoses, including hypertension, paralysis agitans, edema, and ulcers on the heel and midfoot. The resident's recapitulated November 2015 Physician's Orders and MAR documented: 4/23/15 - "Comperm toe to top of calf right side. Do not apply TED hose and use only comperm daily for off-loading. Diagnosis: Open wound."	F 309	F- 309 Resident #4 is receiving wound care and having compression hose (edema care) applied in accordance with Physician Orders. Resident #8'□s peri-stomal skin was examined at the Ostomy Clinic and new orders were received for providing skin care using the crusting technique during ostomy bag changes. Peri-stomal skin has improved since initiation of this technique. Current residents with ostomies have had their peri-stomal skin examined and there were no other findings. Current residents with wound care and edema care (compression stockings) have been reviewed and are receiving care per Physician Orders. LN□s have been re-educated on Physician notification when receipt of an	1/15/16

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F 309	Continued From page 3 6/25/15 - "Use TED (compression) hose on the left lower leg for control of edema. Use Mepilex to pad the bend of the left ankle and apply once a day." An In-Room Skin Care Plan documented Resident #4 was at high risk for skin impairment and was to receive treatments per physician order. On 11/17/15 at 8:45 AM, 9:30 AM, and 11:40 AM; 11/18/15 at 11:25 AM and 2:30 PM; and 11/19/15 at 9:00 AM and 11:25 AM, the resident was observed in the Annex common area seated in a wheelchair. The resident's legs and feet were supported by the wheelchair's leg and foot rests. The resident wore white crew socks and blue protective boots on both feet, but did not have a compression stocking on his left leg or a compression wrap in place on the right leg during observations on 11/18/15 and 11/19/15. On 11/19/15 at 11:05 AM, RCM #1 said orders for the right leg compression wrap and left leg compression stocking were current and the resident should have been wearing both. On 11/19/15 at 11:30 AM, the surveyor observed RCM and LN #2 taking Resident #4 to his room. RCM #1 and LN#2 removed the resident's crew socks and said he did not have the comperm wrap on the right leg or the compression hose on the left leg and ankle as ordered. LN #2 stated the compression hose and compression wrap had not been reapplied following the resident's shower that morning. 2. Resident #8 was admitted to the facility on	F 309	ordered medication is delayed, so that during the interim, a different medication (that is available for use) can be initiated by the DON and /or designee. LN□s have been re-educated on edema care (use of compression stockings) and wound care being completed per Physician Orders by the DON and / or designee. LN's are visualizing residents daily to ensure compression stockings have been applied and removed at the appropriate times via physician order. Resident Care Managers (RCM□s) will review new Physician Orders daily in Managing Acute Condition Changes (MACC) meeting and then verify by reviewing the Medication or Treatment Records that the new medications have been initiated, or the Physician had been notified for interim orders, until the medication is received x 1 month and then weekly x 2 months. Copies of audit will be forwarded to the DON for review and follow-up as needed. The DON will track and trend the audit results and report findings to the QAPI meeting monthly x 3 to identify opportunities for performance improvement. Resident Care Managers (RCM's) will pull an up to date report from our medical record system of all in house resident with a physicians order for compression stockings and do a visual check of each resident to assure they have been applied correctly and at the appropriate times (per the MD order) weekly x4 weeks, then	

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F 309	Continued From page 4 2/27/12 with multiple diagnoses, including diabetes and a colostomy. An "LN to Physician" communication form documented: 10/21/15 - "Resident has a red circle area that is 'yeasty' in appearance around the edge of her colostomy. Please advise. 10/21/15 - Physician Order: "Lotrimin cream to area twice a day until resolved." Resident #8's Ostomy Care Plan documented: Goals:" Ostomy care will be managed appropriately: appropriate amount of drainage, type, color, odor, stoma will be pink, free of breakdown or infection, surrounding skin free of rash, breakdown or infection." Interventions: "Check stoma and surrounding skin for breakdown, rash or infection." The resident's Nursing Progress Notes documented: 10/21/15- 9:43 AM: "Fax to [the physician] regarding discovery of a yeasty appearance to skin around the outside and under the edge of her colostomy bag tape. Placed on alert charting to monitor. Waiting for reply." 10/21/15- 11:07 PM: "New order received. Lotrimin cream to stoma area twice a day until resolved." 10/22/15- 12:32 PM: "Resident on alert charting to monitor redness around colostomy bag. Area continues. Waiting to get Lotrimin." 10/22/15- 8:48 PM: "Unable to do treatment to colostomy area, because it [Lotrimin] is currently out of stock. Area is still red." 10/23/15- 2:05 PM: "Resident on alert for red area around colostomy bag. Lotrimin cream still	F 309	monthly x 2 months. Copies of audit will be forwarded to the DON for review and follow-up as needed. The DON will track and trend the audit results and report findings to the QAPI meeting monthly x 3 to identify opportunities for performance improvement. The DON will ensure compliance. Date of compliance 12/24/2015.	

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F 309	Continued From page 5 has not showed up, area still red, denies pain, will continue to monitor." 10/23/15- 9:36 PM: "Resident on alert charting for red area around stoma. Area continues to be red. Resident denied any complaints of pain to area. New bag applied as old one was lifting on the corner." 10/24/15- 7:42 PM: "Lotrimin cream applied." *Resident #8's October 2015 MAR documented the Lotrimin Cream was applied twice a day, beginning with the morning shift on 10/24/15. On 11/17/15 at 12:55 PM, Resident #8 stated staff treated the red and irritated skin around her stoma periodically itched and/or hurt. On 11/19/15 at 10:35 AM, RCM #1 said the Lotrimin cream "must not have been" available and was on backorder from the pharmacy. When asked, RCM #1 stated the facility could not show the resident's physician was notified of the 82-hour delay.	F 309		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 431		12/24/15

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F 431	Continued From page 6 instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure expired medications were not available for administration to residents and expired biological supplies were not available for laboratory testing. This created the potential for sub-optimal efficacy for any resident who could have received the expired medications and any resident who had blood drawn who could have altered laboratory results with the use of expired test tubes. Findings include: 1. On 11/19/15 at 9:50 AM, during an observation of the Central Supply Room with RCM #1 and CSS #4 in attendance, the following were found:	F 431	F-431 There were no residents identified. The Central Supply, Medication Rooms and Medication Carts were inventoried for expired medications and biological supplies, by Licensed Nursing staff and repeated on 12/10/15 by the Propac Pharmacy Nurse Consultant. Any expired medication or biological supply that was found to be expired was disposed of in accordance with standards of practice. The Central Supply Director and LN□s	

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F 431	Continued From page 7 *2 bottles of oyster shell calcium tablets with an expiration date of 11/14/15 *2 bottles of CertaVite liquid multivitamins and antioxidants with an expiration date of 7/15/15 *2 bottles of menthol 8% liquid spray with an expiration date of 8/15/15 *2 bottles of Garlic Soft Gels with an expiration date of 5/15/15 *1 bottle of lactobacillus tablets with an expiration date of 10/15/15 *1 bottle of Lutein soft gels with an expiration date of 10/15/15 *1 bottle of selenium delayed release tablets with an expiration date of 10/14/15 *1 bottle of selenium delayed release tablets with an expiration date of 9/14/15 *3 bottles of selenium sulfide 1% liquid with an expiration date of 9/14/15 *1 bottle of T-Gel coal tar 0.5% liquid with an expiration date of 4/12/15 *1 bottle of Nizoral with 1% ketoconazole liquid with an expiration date of 10/15/15 *1 bottle of loperamide liquid with an expiration date of 6/15/15 *3 boxes of phenylephrine HCL 0.25% suppositories with an expiration date of 7/15/15 *2 boxes of Preparation H suppositories with an expiration date of 11/13/15 *11 nicotine 21 mg patches with an expiration date of 8/15/15 *9 bottles of isopropyl rubbing alcohol with an expiration date of 11/4/15 *6 bottles of hydrogen peroxide with an expiration date of 11/14/15 On 11/19/15 at 10:05 AM, RCM #1 and CSS #4 both said the outdated medications should not be	F 431	were re-educated on reviewing expiration dates of medications and biologicals prior to moving them from Central Supply to Medication Rooms and before usage for a resident, by the DON and/or designee. The Central Supply Director will conduct a monthly inventory of all medications and biological supplies in Central Supply for expired medications and biological supplies. Copies of inventory findings will be forwarded to the DON for review and follow up, as needed. The Propac Pharmacy Nurse Consultant will complete an audit of Medication Rooms and Medication Carts, for expired medications and biological supplies, during her visits and forward results to the DON, for review and follow up, as needed. The DON will track and trend inventory and audit findings monthly x 3 months and report results to the QAPI Committee to identify opportunities for performance improvement. The DON will ensure compliance. Compliance Date 12/24/2015	

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F 431	Continued From page 8 available for use. On 11/19/15 at 10:20 AM, the CSS said the medications were available to all LN's and that she would dispose of the identified outdated medications. 2. On 11/19/15 at 9:20 AM, nine outdated red-topped laboratory vacutainer collection tubes containing a clot activator and one outdated light green-top laboratory vacutainer collection tube containing sodium heparin were found in the Main Hall Treatment Room with RCM #1 in attendance. RCM #1 said the laboratory testing supplies were expired and should not be available for use. The RCM said she would properly dispose of the expired tubes.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must	F 441		12/24/15

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	135103		11/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESTIGE CARE & REHABILITATION - THE ORCHARDS	1014 BURRELL AVENUE LEWISTON, ID 83501

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F 441	Continued From page 9 isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure infection control procedures were followed for two sampled residents (#9 and #10). Failure to performed hand hygiene after personal cares for Resident #9 and direct contact with Resident #10's Intravenous (IV) resulted in the potential for cross-contamination of bacteria, viruses, and other microorganisms. Findings include: 1. On 11/17/15 at 11:57 PM, LN #3 was observed performing wound care and changing a dressing on Resident #9's sacral wound. After performing the wound care, LN #3 removed her gloves, disposed of them into the trash can, and walked into the hallway. When asked about washing her hands, LN #3 stated, "I'll do it right now." 2. On 11/18/15 at 12:30 PM, LN #3 was observed administering Intravenous (IV) Vancomycin to Resident #10. LN #3 started the infusion,	F 441	F-441 Residents #9 and #10 have not had any adverse effects or infections develop d/t lack of LN hand hygiene. Current residents are receiving care and services in accordance with Infection Control standards for Hand Hygiene, by the staff providing care. LN□s were re-educated on Prestige Care Infection Control Policy and Procedure (P & P) for Hand Hygiene during care of residents receiving wound care and Intravenous (IV) medications by the DON and/or designee. Hand Hygiene competencies have been completed for current LN staff.	

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	135103		11/19/2015

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PRESTIGE CARE & REHABILITATION - THE ORCHARDS	1014 BURRELL AVENUE LEWISTON, ID 83501

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F 441	Continued From page 10 removed her gloves, removed three tubing sets that were not in use, walked out of the resident's room to the nurse's station, where she touched the door. When asked, LN #3 stated she did not perform hand hygiene before leaving the resident's room.	F 441	The Staff Development Coordinator (SDC) will complete random audits of LN□s during wound care and administration of IV medications weekly x 1 month and biweekly x 2 months. Copies of audits will be forwarded to the DON for review and follow up, as needed. The DON will track and trend the audit findings and report results to the QAPI meeting monthly x 3 months to identify opportunities for performance improvement. The DON will ensure compliance. Compliance Date □ 12/24/2015	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it	F 514	F-514	12/24/15

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	135103		11/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESTIGE CARE & REHABILITATION - THE ORCHARDS	1014 BURRELL AVENUE LEWISTON, ID 83501

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F 514	Continued From page 11 was determined the facility failed to maintain clinical records for each resident that were complete and accurate. This was true for 3 of 15 sampled residents (#s 1,4, & 8) and created the potential for medical decisions to be based on incomplete or inaccurate information, which increased the risk for complications due to inappropriate care or interventions. Findings included: 1. Resident #1 was admitted to the facility on 6/28/12 with multiple diagnoses, including Huntington's Chorea, nausea and GERD (gastro esophageal reflux disease). The resident's recapitulated November 2015 Physician's Orders and MAR documented three medications for which no clinical indication was provided. These medications included Prilosec, Risperdal, and Zofran. On 11/19/15 at 10:25 AM, RCM #1 said the diagnoses codes should be documented on each resident's medication record. 2. Resident #4 was admitted to the facility on 2/2/15 with multiple diagnoses, including hypertension, paralysis agitans, congestive heart failure, prostate hypertrophy, reflux, glaucoma, insomnia, and ulcers on the heel and midfoot. The resident's recapitulated November 2015 Physician's Orders and MAR documented 11 medications for which there was no clinical explanation for use provided. These medications included Brimonidine, Digoxin, Dorzolamide, Flomax, Latanoprost, Metoprolol Tartrate, Sinemet, Tylenol, Multivitamin with minerals,	F 514	Resident #1'□s Physician Orders and Medication Record (MAR) have been updated to include Clinical Indication (Diagnosis) for Prilosec, Risperdal and Zofran. Resident #4'□s Physician Orders and MAR have been updated to include Clinical Indication (Diagnosis) for Brimonidine, Digoxin, Dorzolamide, Flomax, Lataanoprost, Metropolol Tartrate, Sinemet, Tylenol, Multivitamin with minerals, Omeprazole and Trazadone. The Physician Orders and MAR reflect the use and side effect monitoring of Buspar. Resident #8'□s Physician Orders and MAR have been updated to include Clinical Indication (Diagnosis) for Metformin, Adalat CC, Calcium, Potassium Chloride, Zocor, Miralex Powder, Celexa, cyanocobalamin, PreserVision, Asprin, Losartan, Multivitamin, Prochlorperazine Maleate and Tramadol. Current residents' Physician Orders and MAR□s have been reviewed and updated to reflect Clinical Indication (Diagnosis), as needed, by the Medical Record□s Director. The RCM□s have been re-educated that during end-of-month recap□s, that they review the Physician Orders and MAR□s to ensure there is a Clinical Indication	

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	135103		11/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESTIGE CARE & REHABILITATION - THE ORCHARDS	1014 BURRELL AVENUE LEWISTON, ID 83501

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F 514	Continued From page 12 Omeprazole, and Trazodone. Resident #4's October and November 2015 MAR documented no side effects were noted for the administration of Ativan from 10/1/15 through 11/18/15. The resident Physician's Orders, dated 7/20/15, documented Ativan was discontinued due to abnormal side effects and Buspar 5 mg three times a day as needed was ordered effective 7/20/15. On 11/19/15 at 11:05 AM, RCM #1, stated the resident's Ativan order was changed to Buspar, which was being monitored by nurses, although the MAR stated the medication received by the resident and monitored by nurses was documented as "Ativan Xanax." RCM #1 said the lack of diagnoses for medications on the resident's Physician's Orders and MAR also needed to be corrected. 3. Resident #8 was admitted to the facility on 2/27/12 with multiple diagnoses, including diabetes, hypertension, pernicious anemia, weight loss, osteoporosis, hypopotassemia, macular degeneration; depression, hyperlipidemia, pain, and nausea. The resident's recapitulated November 2015 Physician's Orders and MAR documented 14 medications for which there was no clinical explanation for use provided. These medications included Metformin, Adalat CC, Calcium, Potassium Chloride, Zocor, Miralax Powder, Celexa, Cyanocobalamin, PreserVision, Aspirin,	F 514	(Diagnosis) for every medication listed, by the DON and/or designee. The DON will do random audits of Physician Orders and MAR□s following the monthly recap□s, to ensure Clinical Indication (Diagnosis) are present for every medication listed x 3 months. The DON will track and trend audit findings and report results to the QAPI meeting for performance improvement x 3 months. The DON will ensure compliance. Compliance Date □ 12/24/2015	

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	135103		**11/19/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESTIGE CARE & REHABILITATION - THE ORCHARDS	**1014 BURRELL AVENUE** **LEWISTON, ID 83501**

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F 514	Continued From page 13 Losartan, Multivitamin, Prochlorperazine Maleate, and Tramadol. On 11/19/15 at 10:35 AM, RCM #2 said Resident #8's Physician's Orders and MAR did not document the resident's diagnoses for the prescribed medications.	F 514		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	MDS001760		11/19/2015

NAME OF PROVIDER OR SUPPLIER: PRESTIGE CARE & REHABILITATION - THE OF

STREET ADDRESS, CITY, STATE, ZIP CODE: 1014 BURRELL AVENUE LEWISTON, ID 83501

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C 000	16.03.02 INITIAL COMMENTS The following deficiencies were cited during the state licensure survey conducted at the facility from November 16 to November 19, 2015. The surveyors conducting the survey were: Amy Barkley, RN, BSN, Team Coordinator Linda Hukill-Neil, RN Angela Morgan, RN, BSN Definitions include: ICC - Infection Control Committee	C 000		
C 664	02.150,02,a Required Members of Committee a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on staff interview and review of Infection Control Committee (ICC) meeting minutes, it was determined the facility failed to ensure a representative from each department was included and attended the ICC meetings every quarter. This failure created the potential for a negative infection-related effects for all residents including 15 of 15 sampled residents (#s 1-15), staff, and visitors to the facility. Findings included: On 11/18/15, the infection control quarterly meeting attendance was reviewed with the Infection Control Nurse and the DON. The Infection Control Nurse stated the ICC meets monthly but does not use attendance sheets. The DON stated the Pharmacist had not regularly attended meetings. The DON stated Infection	C 664	C66 There were no resident□s identified. Facility QAPI Committee meeting will be 12/18/15 and attended by those required to review the Infection Control report, ie. Medical Director, housekeeping services representative, and maintenance services representative. Monthly QAPI meetings are scheduled for the 3rd Thursday of every month. Medical Director and pharmacy consultant have agreed to attend one of the same meetings every quarter.	12/24/15

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed

TITLE:

(X6) DATE: 12/11/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	MDS001760		11/19/2015

NAME OF PROVIDER OR SUPPLIER
PRESTIGE CARE & REHABILITATION - THE OF

STREET ADDRESS, CITY, STATE, ZIP CODE
1014 BURRELL AVENUE
LEWISTON, ID 83501

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C 664	Continued From page 1 Control is discussed during the Quality Assurance (QA) meeting. Review of QA meeting attendance records revealed the following ICC members were not present at the quarterly meetings: *1st Quarter, 5/29/15: DON, Pharmacy, and Housekeeping representative; *2nd Quarter, 7/31/15: Dietary Services Supervisor, Pharmacy, and Housekeeping representative; *3rd Quarter, 8/28/15: Medical Director, Dietary Services Supervisor, and Housekeeping representative. On 11/18/15 at 3:55 PM, the DON with the Administrator present, was asked to provide any additional documentation regarding attendance of the ICC. No further documentation was provided.	C 664	Medical Director and Pharmacy consultant were educated on the requirements of the Idaho tag 0664-02.150,02,a. Both parties understand this requirement. Staff Development Director or designee will contact the medical director and pharmacy consultant via phone and or email 1 week prior to the scheduled monthly meetings to offer a reminder of the meeting dates and times. The DON or designee will ensure that meeting minutes were the medical director and or pharmacy consultant can not attend (no more than 2 months per quarter) are reviewed and signed. The Administrator will ensure that required members of the committee are present each month at the QAPI meeting and that the Medical Director and Pharmacist sign the attendance sheet after reviewing the committee notes, if unable to be present. Date of compliance -12/24/2015	

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

TAMARA PRISOCK—ADMINISTRATOR
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January 27, 2016

Ron Barnes, Administrator
Prestige Care & Rehabilitation-- The Orchards
1014 Burrell Avenue
Lewiston, ID 83501-5589

Provider #: 135103

Dear Mr.. Barnes:

On **November 19, 2015**, an unannounced on-site investigation of an entity-reported incident was conducted at Prestige Care & Rehabilitation-- The Orchards. The entity-reported incidents, findings and conclusions are as follows:

Entity-Report Incident #ID00007032

Allegation #1:

A staff member yelled the "F" word several times in the presence of other residents in the smoking area.

A staff member who wittnessed the incident did not immediately report the incident as potential verbal abuse.

A resident was informed by the facility that law enforcement would be contacted if he/she attempted to leave the without authorization.

Findings #1:

The complaint was investigated in conjunction with the facility's Federal Recertification survey from November 16, 2015 to November 20, 2015.

The the facility's grievance file, Resident Council Meeting minutes, Incident/Accident reports, and Abuse Investigation reports from May to November 2015 were reviewed.

Fifteen resident records did not document concerns related to the use of foul language. The facility's abuse policy and procedure was implemented upon notification of the identified incident.

Eight residents were interviewed regarding Quality of Care and Quality of Life concerns and verbalized they felt safe in the facility and the staff treated them with respect. Three residents' family members were interviewed regarding Quality of Care and Quality of Life concerns and verbalized the facility staff were respectful towards the residents and were prompt to resolve grievances. Five residents interviewed during the group meeting stated they had never been sworn at by staff and had never heard staff swear at other residents. Three Unit Managers, four floor nurses, and five CNAs stated they had not heard staff swear at residents nor did they have concerns regarding the safety of residents. Five direct care staff and three supervisors stated abuse training is completed upon hire, quarterly, and annually. The staff were able to verbalize the types of abuse, when abuse should be reported, and whom it should be reported to.

Resident and staff interactions observed on various shifts from November 16, 2015 to November 20, 2015 were appropriate and respectful.

The facility's completed investigation documented thirty residents were interviewed and stated they felt safe in the facility and had not heard staff using foul language towards residents.

The facility's incident reports, grievances, and Resident Council meeting minutes from May 2015 through June 2015 did not document concerns related to staff using foul language towards residents.

The facility reported the incident to the appropriate licensing agency for review.

The survey team interviewed ten residents, five CNAs, and three frontline supervisors who stated they had not heard staff use foul language towards residents. The CNAs were able to provide examples of verbal abuse and stated it should be reported immediately to the nurse.

Based on observations, interviews, and record/policy review, it was determined there was no deficient practice.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

Sincerely,

David Scott, RN, Supervisor
Long Term Care

DS/lj