



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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RICHARD M. ARMSTRONG – Director

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January 11, 2016

Shelly Henderson, Administrator
Payette Center
1019 Third Avenue South
Payette, ID 83661-2832

Provider #: 135015

Dear Ms. Henderson:

On January 5, 2016, an on-site revisit of your facility was conducted to verify correction of deficiencies noted during the survey of October 9, 2015. Payette Center was found to be in substantial compliance with federal health care requirements regulations as of **December 16, 2016**.

Thank you for the courtesies extended to us during our on-site revisit. 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, R.N., Supervisor
Long Term Care

DS/lj

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

PRINTED: 01/12/2016
FORM APPROVED
OMB NO. 0938-0391

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|---|--|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135015 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED R 01/05/2016 |
| NAME OF PROVIDER OR SUPPLIER PAYETTE CENTER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1019 THIRD AVENUE SOUTH PAYETTE, ID 83661 | | |
| (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} | <p>INITIAL COMMENTS</p> <p>An on-site follow-up to a recertification survey was conducted at the facility from January 4, 2016 to January 5, 2016.</p> <p>The surveyors conducting the survey were: Amy Barkley, RN, BSN, Team Coordinator Angela Morgan, RN, BSN</p> | {F 000} | | | |

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

TITLE

(X6) DATE

Electronically Signed

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.