



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
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CERTIFIED MAIL: 7007 3020 0001 4044 7298

April 15, 2013

Chuck Williams, Administrator
Payette Care & Rehabilitation Center
1019 Third Avenue South
Payette, ID 83661-2832

Provider #: 135015

Dear Mr. Williams:

On **March 29, 2013**, a Recertification and State Licensure survey was conducted at Payette Care & Rehabilitation Center by the Department of Health & Welfare, 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, and a similar State Form 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" (listed on page 3). **Please provide ONLY ONE completion date for each federal and state tag 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

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sign both Form CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **April 29, 2013**. Failure to submit an acceptable PoC by **April 29, 2013**, may result in the imposition of civil monetary penalties by **May 20, 2013**.

The components of a Plan of Correction, as required by CMS include:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. This monitoring will be reviewed at the follow-up survey, as part of the process to verify that the facility has corrected the deficient practice. Monitoring must be documented and retained for the follow-up survey. In your Plan of Correction, please be sure to include:
 - a. Specify by job title who will do the monitoring. It is important that the individual doing the monitoring has the appropriate experience and qualifications for the task. The monitoring cannot be completed by the individual(s) whose work is under review.
 - b. Frequency of the monitoring; i.e., weekly x 4, then q 2 weeks x 4, then monthly x 3. A plan for 'random' audits will not be accepted. Initial audits must be more frequent than monthly to meet the requirement for the follow-up.
 - c. Start date of the audits;
- Include dates when corrective action will be completed in column 5.

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.

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

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 **May 3, 2013 (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 **May 3, 2013**. A change in the seriousness of the deficiencies on **May 3, 2013**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **May 3, 2013** includes the following:

Denial of payment for new admissions effective **June 29, 2013**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, 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 **September 29, 2013**, 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, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0036; phone number: (208) 334-6626; 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.

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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 **March 29, 2013** 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 noncompliance 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 **April 29, 2013**. If your request for informal dispute resolution is received after **April 29, 2013**, 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, please contact us at (208) 334-6626.

Sincerely,



LORENE KAYSER, L.S.W., Q.M.R.P., Supervisor
Long Term Care

LKK/dmj
Enclosures

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 03/29/2013
NAME OF PROVIDER OR SUPPLIER PAYETTE CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 3RD 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	INITIAL COMMENTS The following deficiencies were cited during the annual recertification survey of your facility. The surveyors conducting the survey were: Nina Sanderson, LSW BSW Team Coordinator Patricia O'Hara, RN Ashley Anderson, QMRP Survey Definitions: BIMS = Brief Interview for Mental Status BP = Blood Pressure CAA = Care Area Assessment CNA = Certified Nurse Aide DON = Director of Nurses LN = Licensed Nurse LSW = Licensed Social Worker MAR = Medication Administration Record MDS = Minimum Data Set POC = Plan of Care RAI = Resident Assessment Instrument Recap = Physician Recapitulation Orders RN = Registered Nurse TAR = Treatment Administration Record SDC = Staff Development Coordinator F 225 SS=E 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a	F 000	“This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Payette Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.” RECEIVED APR 29 2013 FACILITY STANDARDS per email (X5) completion date changed to 05/03/2013 on 05/01/2013 @ 3:21pm from administrator F 225 Investigation/Report allegations/Individuals ● The investigation reports for incidents involving residents #14, 11, 2, 5, 21, (20 has been discharged), 12, 16, 17, 18, 19, 22, 23, 24, 25, and 26 were reviewed for	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Chuck Williams Adl TITLE: Administrator (X6) DATE: 4/29/13

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 225	<p>Continued From page 1</p> <p>court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of investigations and staff interview, it was determined the facility failed to ensure all allegations of abuse, neglect and/or mistreatment were thoroughly investigated, and appropriate corrective action was taken. That failure directly impacted 16 residents (Residents #2, #11, #12, #14 - #26) involved in significant</p>	F 225	<p>completeness by the administrator and the director of nurses on or before April 30, 2013.</p> <p>1.a. Resident #14 was re-interviewed by the director of nurses on or before April 30, 2013 and was unable to provide an accurate statement of events leading to the bruise on her neck. The resident was assessed upon discovery of the bruise and states she had no pain related to the bruise on her neck by the director of nursing on 3/7/2013.</p> <p>b. The investigation file for resident #14 was updated by the Director of Nursing or designee on or before April 30, 2013 to include witness statements and the investigation that indicated how the bruise occurred.</p> <p>c. Resident # 14 investigation file was updated by the director of nurses on or before April 30, 2013 to include the names of staff members identified as well as their statements.</p> <p>d. the name of cna #7 who reported the bruise on resident # 14 to the lpn was added to the investigation file on or before April 30, 2013 by the director of nurses.</p>		

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F 225	<p>Continued From page 2</p> <p>incidents. This resulted in a lack of sufficient information being available on which to base corrective action decisions. Investigations from November 2012 through March 2012 were reviewed. The findings included, but were not limited to, the following:</p> <p>1. An investigation, dated 3/7/13, documented a bruise of unknown origin on Resident #14's neck.</p> <p>a. The investigation stated, "Resident was not aware of bruise looking mark, stated no pain associated with mark on neck." Resident #14's statement, including her account of what had made contact with her neck recently, was not included with the investigation.</p> <p>b. The investigation labeled the incident as "self-inflicted injury." There was no documentation to explain how that conclusion was reached.</p> <p>c. The investigation stated, "cna notified lpn of bruise.." However, no details regarding the name of the CNA or LPN, or their statements, were included with the investigation.</p> <p>d. Under the section Witness(es), the investigation listed CNA #7. It was unclear from the report if CNA #7 was the CNA who notified an LPN, or if the CNA was another nurse on shift.</p> <p>e. The investigation did not include documentation of an interview with the LPN.</p> <p>f. The investigation did not include interviews of all staff working that shift to determine if anyone was aware of how Resident #14 acquired the</p>	F 225	<p>e. The referenced LPN was re-interviewed and the interview statement was added to the investigation file for resident #14 by the director of nurses on or before April 30, 2013.</p> <p>f. Staff working the shift and the prior shift the bruise was reported were re-interviewed by the director of nurses or designee on or before April 30, 2013, and their statements included in the investigation file for resident # 14.</p> <p>g. the bruise was not reported to the Bureau of Facility Standards because the label "injury of unknown origin" was an error in documentation due to the fact it was witnessed by staff, therefore not of unknown origin. The title of the incident report for resident #14 was changed from a injury of unknown origin to a self inflicted injury due to the fact that this was a witnessed event. The event was not reported because it was a witnessed event.</p> <p>h. Resident #14 investigation file was updated by the Director of Nursing on or before April 30, 2013 to include the location of the bruise on Resident #14's neck.</p> <p>2.a. RN #1 was re-interviewed by the administrator and notes of the interview were</p>		

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F 225	<p>Continued From page 3</p> <p>injury. Additionally, the incident did not include statements from staff over past shifts to determine the source of the bruise.</p> <p>Without details from interviews with all staff, the facility could not comprehensively assess the source of the injury and how to prevent injuries in the future.</p> <p>g. The injury of unknown origin was not reported to the Bureau of Facility Standards as required in Informational Letter #2005-1.</p> <p>h. The investigation did not document where on Resident #14's neck the bruise was located.</p> <p>2. An investigation, dated 10/12/12, documented an allegation of neglect by CNA #1 to Resident #11.</p> <p>a. Under the Witness(es) section, the report listed the names of CNA #1, CNA #2 and RN #1. The report did not contain any documentation, including a staff statement, that RN #1 was interviewed.</p> <p>b. The investigation documented an interview with CNA #2, under the heading, Summary of Interview with Witness(es)," without details of when the interview took place. No written statement from CNA #2 was included with the investigation.</p> <p>c. Under the heading Summary of Interview with Resident, the investigation documented an interview with Resident #11 without details of when the interview took place.</p>	F 225	<p>added to the investigation file of resident # 11 on 4/23/2013</p> <p>b. The summary of interview with witness statement was updated to include the date the interview took place with CNA #2 by the administrator on or before April 30, 2013 and a summary statement of the interview was added to the investigation file of the event for resident #11 4/23/2013 by the administrator .</p> <p>c. the notes of the interview with resident #11 were updated to include when the interview took place by the Administrator 4/23/2013.</p> <p>d. details of the suspension of c.na #1 for the purpose of protecting the resident were added to the investigation file for resident #11 by administrator on 4/23/2013. The investigation file for resident #11 was updated to reflect the actual date CNA #1 was immediately suspended pending outcome of investigation to ensure resident(s) protection and the Date CNA#1 was allowed to return to work by the administrator on 4/23/2013.</p> <p>e. conclusion information, corrective actions taken, and supporting documentation was added to the investigation file for resident #11 on 4/23/2013 by the administrator.</p>		

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F 225	<p>Continued From page 4</p> <p>d. The investigation stated, "Placed [CNA #1] on suspension until further findings." However, the investigation did not contain details of when CNA #1 was suspended or when she was allowed back to work. It was unclear from the investigation if Resident #11 was immediately protected from possible neglect.</p> <p>e. The investigation did not document any conclusion information, including corrective action.</p> <p>3. An investigation, dated 1/18/13, documented an injury of unknown origin on Resident #2's back, found after Resident #2 complained to a CNA of back pain.</p> <p>a. The investigation did not include interviews of all staff working that shift to determine if anyone was aware of how Resident #2 acquired the injury. Additionally, the incident did not include statements from staff over past shifts to determine the source of the injury.</p> <p>Without details from interviews with all staff, the facility could not comprehensively assess if the injury was from an unavoidable accident or if staff needed re-training on their job responsibilities to prevent further incidents.</p> <p>b. The investigation stated, "CNA's assisting resident to bed..." However, no details regarding the name of the CNAs, or his/her statements, were included with the investigation.</p> <p>c. Under the section Witness(es), the investigation listed CNA #3 and CNA #4. It was unclear from the report if CNA #3 and CNA #4</p>	F 225	<p>3.a. staff working the shift and the prior shift were re-interviewed, and their statements included in the investigation file for resident #2 by the director of nurses on or before April 30, 2013.</p> <p>b. The names and the statements of the C.N.A.s involved in the incident and investigation for resident #2 were included in the investigation file by the director of nurses on or before April 30, 2013.</p> <p>c. The roles of the staff members identified were clarified and the investigation file for resident #2 was updated by the director of nurses on or before April 30, 2013</p> <p>d. Resident #2 was re-interviewed related to the event in question by the director of nurses on or before April 30, 2013. Resident #2 was unable to provide an accurate statement of events regarding the pain in her back. The resident was re-assessed weekly to track the progress of the injury and pain related to the injury by the nurse manager on or before 4/30/2013.</p> <p>e. The incident report for resident #2 was not reported because the source of the injury was determined at the time it was discovered which was the sit to stand lift sling that caused the abrasion. This incident and the follow up investigation notes were reported</p>		

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F 225	<p>Continued From page 5</p> <p>were the CNAs assisting Resident #2, or if the CNAs were other nurses on shift.</p> <p>d. The investigation documented that Resident #2 "said a spot on her back hurt." However, no statement from Resident #2, including her account of how the injury occurred, was included with the investigation.</p> <p>e. The injury of unknown origin was not reported to the Bureau of Facility Standards as required in Informational Letter #2005-1.</p> <p>4. An investigation, dated 3/2/13, documented an injury of unknown origin on Resident #15's anus, found after blood was found in Resident #15's attends and bedpan.</p> <p>a. The investigation did not include interviews of all staff working that shift to determine if anyone was aware of how Resident #15 acquired the injury. Additionally, the incident did not include statements from staff over past shifts to determine the source of the injury.</p> <p>Without details from interviews with all staff, the facility could not comprehensively assess the source of the injury and how to prevent injuries in the future.</p> <p>b. Under the section Witness(es), the investigation listed CNA #8. However, the investigation did not include documentation of an interview with CNA #8.</p> <p>c. The investigation did not include a statement from Resident #15.</p>	F 225	<p>to Facility Standards on or before April 30, 2013 by the Director of Nursing.</p> <p>4.a. staff working the shift were re-interviewed and their statements included in the investigation file for resident #15 by the staff development coordinator on or before April 30, 2013, abuse is not substantiated.</p> <p>b. The investigation file for resident #15 was updated to include documentation of the interview with C.N.A #8 on or before April 30, 2013 by the director of nurses.</p> <p>c. Resident #15 was interviewed by the director of nurses on 3/2/2013 and a summary of the interview was added to the investigation file on or before 4/30/13.</p> <p>d. The incident report for resident #15 was not reported to the Bureau of Facility Standards due to the fact it was not an injury of unknown origin. The origin of the injury was known at the time discovered, and documented in the investigation file. The file was updated with witness statements and a summary of the investigation by the director of nurses on or before 4/30/13.</p> <p>5.a Statement from C.N.A. #6 was added to the investigation file for the event involving resident #20 & #21 on or before April 30,</p>	

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F 225	Continued From page 6 d. The injury of unknown origin was not reported to the Bureau of Facility Standards as required in Informational Letter #2005-1. 5. An investigation, dated 12/21/12, documented an incident of Resident #20 verbally insulting Resident #21. a. Under "Witness(es)," the investigation listed CNA #6. However, the investigation did not include a statement from CNA #6. b. The investigation did not include a statement from Resident #20. d. The investigation documented, "Residents are being kept separate and visible by a staff member at all times." The investigation did not contain any additional information regarding the separation of residents (i.e. how long were they required to be separated, was the team aware of the decision, was the separation and instruction for staff included in Resident #12 and Resident #13's plans of care, etc.). 6. There were similar findings for Residents #12, #16, #17, #18, #19, #22, #23, #24, #25 and #26. When asked about the thoroughness of the investigations the Administrator stated, in an interview on 4/1/13 at approximately 3:00p.m., he did not have any additional documentation to evidence the thoroughness of the investigations. The facility failed to ensure all allegations of abuse, neglect or mistreatment were thoroughly investigated.	F 225	b. Resident #20 has been discharged from the facility. d. The details of keeping residents #20 and #21 separated was included in the investigation file by the Administrator on or before April 30, 2013. 6. The investigation files for incidents involving residents #12, 16, 17, 18, 19, 22, 23, 24, 25 and 26 were reviewed on or before April 30, 2013 by the administrator. Summaries of staff statements, staff identifications, conclusions and supporting documentation as identified and applicable were obtained or clarified and the investigation files updated by the Administrator or Designee on or before April 30, 2013. Residents #16, 17, 18, 19, 23, 24, 25 have been discharged from the facility. Residents #12, 22, and 26 were assessed by the Director of Nursing or Designee on or before April 30, 2013 with no adverse physical or psychosocial issues noted post identified events. ● An audit of all reported resident incidents since March 29, 2013 was done by the administrator on or before April 30, 2013.		
F 226	483.13(c) DEVELOP/IMPLMENT	F 226			

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F 226 SS=E	<p>Continued From page 7 ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review and staff interview, it was determined the facility failed to sufficiently develop and operationalize policies and procedures that prohibited mistreatment, neglect, and abuse of residents and misappropriation of resident property for 16 residents (Residents #2, #11, #12, #14 - #26) involved in significant incidents, with the potential to affect all residents residing in the facility. That failure resulted in potential harm by not clearly specifying how staff were to handle allegations of abuse, neglect or mistreatment. The findings include:</p> <p>1. The facility's abuse policy, revised November 2010, was reviewed and was not sufficient to ensure residents were not subjected to mistreatment, neglect, abuse, and misappropriation of their property as follows:</p> <p>a. Under the section titled Training, it stated "Train employees, through orientation and ongoing sessions..."</p> <p>The policy did not contain information related to how ongoing training would be conducted, at what frequency, or who was responsible for training staff.</p>	F 226	<p>Missing information such as staff identification, witness statements, including date and time of interviews, resident statements where appropriate, including date and time of interview, conclusion statements and supporting documentation were added to the investigation files as needed. Reports to the state were filed as needed.</p> <ul style="list-style-type: none"> • The IDT was re-educated on abuse prevention, reporting and investigation by the Regional Nurse on or before April 29, 2013. • Beginning the week of 4/30/2013 an audit of 5 investigations will be completed by the Administrator and/or designee weekly for 4 weeks, then monthly for 2 months, The results of these audits will be reported to the Performance Improvement Committee monthly for 3 months. The Administrator is responsible for monitoring and follow up and report findings. • April 30, 2013 		

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F 226	Continued From page 8 b. Under the section titled Protection, it stated prevention of further abuse during investigation could include: - Removing the accused employee from the resident care area immediately pending investigation. - Removing the staff member from the schedule until the results of an investigation were known. - Temporary room re-assignments when resident to resident incidents occur. The policy did not include information related to who was authorized to make these decisions. c. Under the section titled Reporting/Response, it stated incidents involving "serious bodily injury" should be reported within 2 hours and incidents not involving "serious bodily injury" should be reported within 24 hours. The policy did not define "serious bodily injury." d. Under the section titled Reporting/Response, it stated if there "is a reasonable suspicion of criminal activity against a resident, a report must be filed with the local police. Confer with the [facility] Law Department prior to police notification." When asked about the Law Department, the Administrator stated in an interview on 3/28/13 from 3:20 - 3:40 p.m., the Law Department was a facility department based out-of-state and the phone number was posted in the facility for staff use.	F 226	F 226 Develop/Implement Abuse/Neglect, etc Policies. 1. Residents #2, #11, #12, #14-#26 were assessed for signs or symptoms of abuse or neglect by the Director of Nursing of designee on or before 4/30/13 with none noted. The center's abuse policy was updated and adopted by the Performance Improvement Committee at Payette Rehabilitation and Care Center on 4/25/2013 the updated policy includes components per the State and Federal Regulations. 2. 5 residents from each unit were interviewed and assessed for signs or symptoms of abuse by the Director of Nursing or designee on or before 4/30/13. No signs or symptoms of abuse were noted. 3. Center staff was educated on the facilities newly adopted abuse policy by the Administrator on or before 4/30/2013. 4. Beginning the week of 4/30/2013 3 random staff members were interviewed related to their understanding of the abuse policy to ensure understanding of its content. Weekly X4 weeks and then monthly X2 months. The results of these audits were reported to the Performance Improvement		

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F 226	<p>Continued From page 9</p> <p>It was unclear why consultation from an out-of-state department was necessary prior to calling local emergency personnel regarding criminal activity in the facility.</p> <p>e. Under the Physical Abuse definition, it referred to corporal punishment. Corporal punishment was not defined.</p> <p>Additionally, the definition included "signs of being restrained" as a symptom of abuse. However, "signs of being restrained" was not defined in policy.</p> <p>Further, when five staff were asked about the signs of being restrained, during interviews on 3/27/13 and 3/28/13, staff stated the following:</p> <ul style="list-style-type: none"> - Sadness, tearfulness, facial expressions. - Marks on the resident - red or bruises. - Sores, such as fingerprints from hands. - Marks wherever the restraint was as well as different reactions from the resident, such as shying back. - Marks such as around the wrist, bed sores from being left in the bed for long periods of time, or bruises. <p>When asked about the signs of restraint, the Administrator stated in an interview on 3/28/13 from 3:20 - 3:40 p.m., the definition was not included in policy and could be referring to multiple types of restraint, such as chemical or physical.</p> <p>f. Under the section titled "Reporting of the allegation includes," it stated all alleged violations were to be immediately reported to the</p>	F 226	<p>Committee monthly X3 months or until resolved. The Administrator is responsible for monitoring and oversight.</p> <ul style="list-style-type: none"> • April 30, 2013 	

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F 226	<p>Continued From page 10 Administrator and DON.</p> <p>The policy did not include information as to what to do if the alleged staff were the Administrator and DON.</p> <p>Additionally, when five staff were asked who they were required to report abuse to, during interviews on 3/27/13 and 3/28/13, staff stated the following:</p> <ul style="list-style-type: none"> - "The first person you report to is the charge nurse." - "I would report to my direct supervisor or the charge nurse or the Administrator and the DON." - "Follow the chain of command. Charge nurse first, then the Administrator." - "The Charge nurse." - "The head nurse and the Administrator." <p>Staff knowledge was not consistent with the reporting requirements specified in the facility policy.</p> <p>g. The section titled "Reporting of the allegation includes" stated the following:</p> <ul style="list-style-type: none"> - Investigate the alleged incident immediately, - Remove/protect the resident from danger, - Conduct interviews of resident(s) and witnesses and obtain written statements, - Notify the DON and Administrator, - Suspend/remove the employee immediately - pending results of the investigation. Instruct the employee not to return to the center until they have spoken with the director of nursing and/or administrator, - Notify the physician, 	F 226		

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F 226	<p>Continued From page 11</p> <ul style="list-style-type: none"> - Notify the family or legal representative, - Notify law enforcement officials as appropriate, as directed by Administrator, - Notify the State Department of Health and other regulatory agencies according to individual state reporting requirements, - Notify appropriate department heads, - Notify the resident care plan coordinator of potential care plan needs, - Notify the social worker to provide counseling and support to the residents and/or families involved. <p>For instructions not specified "immediately," associated timeframes for implementation were not included. Additionally, the policy did not include information related to who was authorized to make these decisions.</p> <p>Further, when five staff were asked when they were required to notify law enforcement during interviews on 3/27/13 and 3/28/13, staff stated the following:</p> <ul style="list-style-type: none"> - "When there is staff to resident abuse, violence against the resident, when residents hit each other, and for any theft." - "I don't know, I would ask the Administrator." - "When an incident is sexual and without the permission of the resident." - "For any physical incidents or threats." - "Any time there is abuse - mainly when it is someone outside of the facility for whom the Administrator cannot conduct disciplinary action." <p>Staff knowledge with reporting requirements for law enforcement was inconsistent.</p>	F 226		

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F 226	<p>Continued From page 12</p> <p>h. Under the section titled "Regardless of the specific allegation, interview," it specified details of who to interview during an investigation.</p> <p>The policy did not include information related to who was authorized to conduct interviews and associated timeframes for implementation.</p> <p>i. Under the section titled Final Investigation Report, it stated the summary, conclusions, and outcomes were to be submitted to the state within 5 days of the event.</p> <p>The policy did not include information related to who was responsible for report submission.</p> <p>j. Under the section titled Understanding Risk Factors, it listed specific things caregivers could do to monitor their own stress level.</p> <p>When asked about signs of burnout during an interview on 3/28/13 from 2:39 - 2:45 p.m., the Activities Director stated the only sign of burnout was staff calling in and asking for their shift to be covered. When asked how she monitored for signs of stress in staff, she stated that last winter the staff were tired and their bodies got stressed and they all got sick.</p> <p>The policy did not include any information related to how management and supervisory staff were expected to monitor for staff stress and burnout.</p> <p>k. The Administrator stated, during an interview on 3/28/13 from 3:20 - 3:40 p.m., facility training emphasized the main role of staff was protection of the resident. However, staff were asked what they would do if they heard the DON yelling at a</p>	F 226		

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F 226	Continued From page 13 resident in their room, during interviews on 3/27/13 and 3/28/13, and staff stated the following: - "I would go get the charge nurse. I would have him or her come with me to witness the abuse and probably call my boss and the Administrator." - "I would go to a superior, probably the Administrator, because I don't know if I 'would have the guts' to intervene myself." - "I would call the DON because she would know what to do. I would also call the charge nurse." - "I would knock, ask if I could help. I would escort the DON out and report to the charge nurse." - "I would let my charge nurse and the Administrator know." Staff failed to consistently put immediate protection of the resident first, per policy and Administrator training. When asked, the Administrator stated during an interview on 3/28/13 from 3:20 - 3:40 p.m., the specifics missing from policy were trained with staff. However, he stated that without supplemental training in policy, the details specific to the facility would not be known. The facility failed to ensure policies and procedures that prohibited mistreatment, neglect, and abuse of residents and misappropriation of resident property were sufficiently developed and operationalized.	F 226			
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically	F 272	F 272 Comprehensive Assessments ● (Resident # 6 (not #5) is addressed here.) Resident #6 discharged on 4/1/2013.		

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F 272	<p>Continued From page 14</p> <p>a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 272	<ul style="list-style-type: none"> ● A review of MDS's done since March 29, 2013 was completed by the MDS nurse manager on or before April 26, 2013, to ensure the CAAs worksheet were completed to include resident's and or family input. ● The Inter Disciplinary Team members who document on the MDS were in serviced by the regional nurse consultant on or before April 30, 2013 regarding completion of the MDS, including CAAs. ● Beginning the week of 4/30/2013 the Director of Nursing Services or designee will audit 3 comprehensive MDS' to ensure complete summary information was documented for the triggered CAA areas weekly for 4 weeks, then monthly for 2 months. The results of these audits will be reported to the PI committee monthly for 3 months or until resolved. The Director of Nursing will be responsible for monitoring and oversight. ● April 30, 2013 		

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F 272	<p>Continued From page 15</p> <p>by: Based on staff interview and record review, it was determined the facility did not ensure documentation of summary information on the CAAs triggered by the MDS. This was true for 1 of 5 residents (Resident #5) reviewed for completion of MDS assessments. The deficient practice had the potential to cause more than minimal harm when the facility did not use the information gathered on the MDS to revise a resident care plan to reflect her changing needs and condition. Findings included:</p> <p>Resident #6 was admitted to the facility on 11/18/10 and re-admitted on 1/18/13 with diagnoses which included UTI, sepsis, dementia due to cerebrovascular disease, insulin dependent diabetes mellitus, severe hypertension, and chronic kidney disease with superimposed acute renal failure.</p> <p>On 2/1/13, a physician's order documented, "Hospice evaluation." Resident #6's record documented she enrolled in hospice care on 2/4/13.</p> <p>On 2/6/13, the facility completed a change of condition MDS assessment. Section V of that MDS documented CAA trigger areas of Cognitive Loss/Dementia, ADL Function, Urinary Incontinence, Psychosocial Well-Being, Mood State, Behavioral Symptoms, Activities, Falls, Nutritional Status, Dehydration, Pressure Ulcer, and Psychotropic Drug Use.</p> <p>Within the CAAs, the areas to "Provide input from resident and/or family representative regarding this care area" documented:</p>	F 272		

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F 272	<p>Continued From page 16</p> <p>-Cognitive Loss, Psychosocial well-being, Mood State, Behavioral Symptoms, and Psychotropic Drug Use, "Family is aware and agreeable with plan of care."</p> <p>-ADL Function Urinary Incontinence, Activities, Dehydration, "resident is agreeable and daughter is very involved in care."</p> <p>-Falls and Pressure Ulcers, "Residetrn [sic] is agreeable to cares and daughter is involved in all cares as well."</p> <p>-Nutritional Status was blank.</p> <p>NOTE: There was no documentation as to what family was aware of, or with what plan of care they were agreeable. There was no documentation of how Resident #6 or her family viewed her declining condition and the addition of hospice in these care areas.</p> <p>The CAA areas for Care Plan Considerations, the areas to describe the impact of the problem/need on the resident and rationale for care plan decisions documented:</p> <p>-Cognitive Loss/Dementia, Psychosocial well-being, Mood State, Behavioral Symptoms, Pressure Ulcers, and Psychotropic Drug Use: All blank.</p> <p>-Activities: "See activities notes."</p> <p>NOTE: Please see F280 as it pertains to care plan revisions.</p> <p>On 3/27/13 at 9:40 AM, the DON, SDC, and Regional Nurse Consultant were asked about the CAA summaries, and how they were used for care plan decisions. The Regional Nurse Consultant reviewed Resident #6's CAA summaries and stated, "There should be more</p>	F 272			

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F 272	Continued From page 17 there."	F 272			
F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility did not update a resident's care plan as her medical condition declined. This was true for 1 of 9 sampled residents (#6) reviewed for care plans.</p>	F 280	<p>F 280 Right to participate in Care Planning</p> <ul style="list-style-type: none"> ● Resident #6 discharged from the center on 4/01/2013. ● A review of residents with significant Change of Condition assessments completed in the past 90 days was completed by the Director of Nursing Service or designee, on or before April 30, 2013 and changes and updates were made to the plan of care as necessary to reflect the resident's preferences, current condition and needed level of support. ● Licensed staff were in serviced by the Staff Development Coordinator on or before April 30, 2013 regarding updating the residents plan of care to reflect the residents current condition and needed level of support. ● Beginning the week of 4/30/2013 the Director of Nursing Services or designee will review 3 care plans for accuracy weekly for 4 weeks, then monthly for 2 months, and 		

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F 280	<p>Continued From page 18</p> <p>The deficient practice had the potential to cause more than minimal harm if staff did not have direction to provide adequate care based on the residents' current needs. Findings included:</p> <p>Resident #6 was admitted to the facility on 11/18/10 and re-admitted on 1/18/13, with diagnoses which included UTI, sepsis, dementia due to cerebrovascular disease, and insulin-dependent diabetes mellitus.</p> <p>Resident #6's Change of Condition MDS Assessment, completed 2/6/13, coded: -Clear speech, able to understand others and make self understood. -Unable to complete BIMS, assessed by staff with moderately impaired decision making skills. -Needed extensive assistance or was totally dependent for ADL's, eating, and mobility.</p> <p>Resident #6's care plan documented:</p> <p>-Focus area for self-care deficit, intervention initiated 1/5/11: **"Encourage Resident to do as much for self as able." -Focus area, "Requires assistance/potential to restore function to maximum self-sufficiency for eating", interventions initiated 1/31/13: **"...provide encouragement and physical assist." **"Place resident at meals with residents who have similar interests/eating manners." -Focus area of personal hygiene, interventions initiated 1/31/13: **"Set up with shaver/make up appliance/brush in residents hand and position in front of mirror." **"Encourage independence." **"Encourage resident to participate in tasks of</p>	F 280	<p>reported to the Performance Improvement Committee monthly for 3 months or until resolved. The Director of Nursing is responsible for monitoring and follow up.</p> <ul style="list-style-type: none"> ● April 30, 2013 	

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F 280	<p>Continued From page 19 choice."</p> <p>-Focus area of altered respiratory status, interventions initiated 1/31/13: **"Encourage Resident to be out of bed as tolerated and exercise." **"Remind Resident not to over exert during activities of daily living."</p> <p>-Focus area of chronic/progressive decline, the interventions, initiated 5/29/11: **"Provide cueing [and] prompting to ensure resident makes attempts at own care before offering assistance," added 1/31/13. **"Provide reality orientation," added 1/31/13.</p> <p>-Focus area of acute confusional state, initiated 1/31/13, the interventions: **"Establish a calm environment." **"Keep environmental stimulus to a minimum." **"Provide sensory stimulation." **"Use orientation techniques"</p> <p>On 3/25/13 at 1:15 PM, Resident #6 was observed in her bed. She was lying on her back, wearing a hospital gown, covered with a sheet and blanket up to her chest. Her eyes were closed; her head was lying against the pillow with her head tilted slightly to the right. There was a teddy bear on the left side of her head. The television in the room was on, tuned to an old western program. No changes were noted during observations at 2:25 PM, 3:10 PM, and 3:40 PM.</p> <p>On 3/26/13 at 7:05 AM, Resident #6 was again observed in bed on her back, head tilted to the right, covered to the chest by a sheet and blanket. Her eyes were closed. The room was dark, but the TV was on with an old western program playing. Resident #6 was still in this position at 8:05 AM when her breakfast tray was</p>	F 280			

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F 280	<p>Continued From page 20</p> <p>brought into her room. The tray was placed on her over bed table and moved next to her bed, but the cover was not removed. Resident #6 did not respond or rouse. At 8:20 AM her breakfast tray was removed. Resident #6 continued in the same position, without waking or rousing, until the end of the morning's observations at 11:50 AM.</p> <p>NOTE: Resident #6 was not observed to eat her meal either in the dining room or her room. She was dependent on staff to anticipate her needs during observations. Her TV was observed on the same type of program during each observation. She was not observed to be given encouragement to increase her independence, nor did she demonstrate awareness of staff or family in the room who were interacting with her.</p> <p>On 3/27/13 at 9:40 AM, the DON, SDC, and Corporate Nurse Consultant were interviewed about Resident #6's care plan. They stated Resident #6 had enrolled in hospice services, and was expected to pass away within the next few days. They stated Resident #6 had become minimally responsive, and was now dependent on staff to care for her and anticipate her needs. They stated historically she had preferred to watch reality TV, so the TV was left on at all times to stimulate her. They were unsure if Resident #6 cared for old westerns. They stated they had not had an opportunity to update Resident #6's care plan since her overall condition had deteriorated.</p> <p>On 3/27/13 at 4:30 PM, the Administrator, DON, and Corporate Nurse Consultant were informed of these findings. The facility offered no further information to resolve these concerns.</p>	F 280			
F 281	483.20(k)(3)(i) SERVICES PROVIDED MEET	F 281	F 281 Services Provided meet Professional Standards.		

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F 281 SS=D	<p>Continued From page 21 PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, review of personnel files, and clinical reference, it was determined the facility failed to ensure residents were provided treatment within nursing professional standards for 1 of 6 residents (Resident #1) whose nursing treatment was reviewed. This resulted in a resident receiving care against physician's orders and by unqualified individuals. Findings included:</p> <p>1. Resident #1's admission Nursing Assessment, dated 2/15/13, documented he was admitted to the facility on 2/15/13 with diagnoses including diabetes and hypertension.</p> <p>Resident #1's record included Interdisciplinary Progress Notes with a nursing entry dated 3/14/13. The entry documented that Resident #1 was being discharged for surgery. At the time of discharge, Resident #1 had treatment orders, including instructions for dressing changes from an order dated 2/26/13, in place related to a pressure ulcer on his right heel.</p> <p>Resident #1's readmission Nursing Assessment, dated 3/17/13, documented Resident #1 returned with the pressure ulcer still on his right heel.</p> <p>A dressing change for Resident #1's right heel pressure ulcer was observed on 3/26/13 from</p>	F 281	<p>F 281 Services Provided meet Professional Standards.</p> <ul style="list-style-type: none"> Resident #1's wound care orders were clarified with MD on or before April 30, 2013 by Director of Nurses or designee. <p>Resident #1's wound was assessed by Director of Nurses or designee on or before April 30, 2013 with no deterioration noted.</p> <p>RN #1 was re-educated by the Director of Nursing on 4/25/2013 related to scope of practice as it relates to conservative sharps debridement and MD orders.</p> <ul style="list-style-type: none"> Residents with wounds were reviewed by the Director of Nursing Service or designee on or before April 30, 2013 for current treatment orders. No other residents with wound care treatments were found to have missing doctor's orders for their wound treatments. <p>Licensed nurses return demonstrations of wound treatments were observed by Director of Nurses or designee, on or before April 30, 2013 and documented to rule out debridement scope of practice violations. No other incidents or findings noted.</p>		

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F 281	<p>Continued From page 22</p> <p>12:55 - 1:30 p.m. Resident #1's pressure ulcer measured 7 cm x 4 cm with partially detached skin extending approximately 1 cm further around the wound.</p> <p>RN #1 was observed to put on gloves, put a paper towel under his foot, and spray the heel with Skintegrity. She attempted to pull off some of the partially detached skin with her hands and then rubbed the skin with a piece of dry gauze. The skin remained partially attached. RN #1 changed her gloves, obtained bandage scissors, wiped them with an alcohol swab, and trimmed off the skin bordering the wound.</p> <p>a. During an interview on 3/27/13 from 2:58 - 3:18 p.m. with the DON, Regional Nurse Consultant, and MDS person, the Regional Nurse Consultant stated the facility did not perform sharp debridement as a form of wound treatment. She stated debridement needed to be completed by the wound clinic.</p> <p>Additionally, Acute and Chronic Wounds by Ruth A. Bryant, 1992, Mosby-Year Book, stated the following on page 57 regarding the requirements for debridement qualifications:</p> <p>- "Conservative instrumental debridement involves removal of loose avascular tissue with sterile instruments; it may be done by the physician or by nurses who have been taught the procedure and have obtained institutional and physician clearance."</p> <p>RN #1's personnel file was reviewed and did not document specialized coursework in Conservative Sharp Wound Debridement or any</p>	F 281	<ul style="list-style-type: none"> ● Licensed nurses were re-educated by the Director of Nurses or designee on or before April 30, 2013 regarding wound care policies and procedures, including the required MD orders and scope of practice as it relates to conservative sharps debridement. ● Beginning the week of 4/30/2013 the Director of Nursing Services or designee will audit newly developed wounds to ensure current wound care orders are in place. And the Director of Nursing or designee will observe 3 random treatments to ensure wound care was completed within the nurses scope of practice weekly for 4 weeks, then monthly for 2 months. The results of these audits and observations will be reported to the Performance Improvement Committee monthly for 3 months or until resolved. The Director or Nursing is responsible for monitoring and follow up. ● April 30, 2013 		

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F 281	<p>Continued From page 23</p> <p>other training specific to wound debridement. Further, the file did not contain documentation of physician or institutional clearance.</p> <p>The Staff Development Coordinator confirmed on 3/28/13 at approximately 11:05 a.m. that none of the nurses on staff at the facility were wound care trained.</p> <p>The facility failed to provide services to Resident #1 within the scope of nursing professional standards.</p> <p>b. Resident #1's record did not contain physician's orders for wound care for his right heel since his readmission on 3/17/13.</p> <p>The Idaho Board of Nursing Rules and Regulations (IDAPA 23.01.01) stated, at IDAPA 23.01.01.401, that a licensed professional nurse (i.e., Registered Nurse) "is accountable and responsible for implementation of planned and prescribed nursing care and implementing orders for medications and treatments issued by an authorized prescriber."</p> <p>During an interview on 3/26/13 from 1:40 - 1:50 p.m., RN #1 stated the dressing had been changed daily as part of Resident #1's routine despite the lack of physician's orders.</p> <p>However, during an interview on 3/28/13 from 9:55 - 10:15 a.m. with the MDS nurse, DON and Regional Nurse Consultant, the MDS nurse stated that the facility had not obtained physician's orders for treatment of Resident #1's heel between 3/17/13 and 3/25/13 because the wound was not draining. She stated the team felt</p>	F 281			

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F 281	Continued From page 24 treatment was not needed. Therefore, staff was instructed to only monitor and measure the wound. Due to the conflicting interviews regarding treatment and physician's orders, Resident #1 was interviewed on 3/29/13 from 9:35 - 9:43 a.m. He stated his wound dressing had been consistently changed daily since his readmission on 3/17/13. The facility failed to provide treatment for Resident #1's pressure ulcer in conjunction with physician's orders as required by nursing professional standards.	F 281			
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, staff interview, and record review, it was determined the facility failed to ensure each resident was provided the necessary care and services to maintain good health for 1 of 6 residents (Resident #1) whose physician's orders were reviewed. This resulted in a resident not receiving treatment for a pressure ulcer as prescribed by a physician. The findings included:	F 309	F 309 Provide Care/Services for Highest Well Being ● Wound clinic was contacted related to resident #1 on 3/29/2013 by MDS coordinator and current treatment and plan of care was reviewed and updated as indicated. The MD made informed of the wound clinic recommendations and assessment. Residents with wounds were reviewed by the Director of Nurses or designee, on or before April 30, 2013 to ensure treatment plan ordered and in place as ordered and no other adverse findings were noted. ● Licensed nurses were re-educated by the director of nurses or designee, on or before April 30, 2013, on obtaining orders for		

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F 309	<p>Continued From page 25</p> <p>1. Resident #1 was originally admitted to the facility on 2/15/13 with diagnoses including diabetes and hypertension.</p> <p>Resident #1's record included a Pressure Ulcer Documentation Form, dated 2/22/13, that documented an unstageable pressure ulcer measuring 6.5 cm x 3.75 cm on his right heel.</p> <p>An appointment note from a wound clinic visit, dated 3/13/13, documented Resident #1 was in "related to his right posterior ulcer on his right foot." Under the section titled Treatment, the note documented "swab the wound with Chloraprep, cover with Mepilex foam, Kerlix and place abdominal pad posterior heel and another Kerlix, medipore tape. Monday, Wednesday, Friday."</p> <p>Further, the note stated, "The nursing facility may continue dressings as above to his right foot and monitor it to make sure it does not deteriorate. Ideally, he should have offloading heel protectors. He is in a wheelchair that has a foam heel protector, however, his heels still rest in that type of foot foam rest. His bony prominences should be assessed every 8 hours..."</p> <p>There was no documentation in Resident #1's record indicating that the dressing orders were implemented. Additionally, there was no documentation related to assessment of Resident #1 every 8 hours as recommended.</p> <p>During an interview on 3/28/13 from 9:55 - 10:15 a.m. with the DON, Regional Nurse Consultant, and MDS nurse, the Regional Nurse Consultant stated the facility did not receive any wound clinic visit notes until 3/22/13. She stated they were</p>	F 309	<p>residents being seen by outside providers when the resident return from the appointment with recommendations.</p> <p>The Health Information Manager was reeducated by the Director of Nursing on or before April 30, 2013 to request progress notes from outside providers not received within 72 hours of appointment in writing.</p> <ul style="list-style-type: none"> Beginning the week of 4/30/2013 The Director of Nursing Services or designee will audit 3 residents going to the wound clinic for current wound care orders, progress notes, and care plan updates, nursing assessment, weekly for 4 weeks, then monthly for 2 months, and reported to the Performance Improvement Committee monthly for 3 months or until resolved. The Director of Nursing is responsible for monitoring and follow up. April 30, 2013 	

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F 309	Continued From page 26 unaware of any treatments given or prescribed by the wound clinic from the initial visit, 3/6/13, forward, due to the lack of dictation. The facility failed to obtain and implement physician's orders for Resident #1. NOTE: Refer to F281 as it relates to the facility's failure to provide treatment and services to Resident #1 in accordance with nursing professional standards.	F 309			
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, it was determined the facility failed to ensure that a resident who entered the facility without a pressure ulcer did not develop a pressure ulcer for 1 of 4 sample residents (Resident #1) reviewed for pressure ulcers. This resulted in a resident developing an avoidable Stage 2 pressure ulcer. The findings included: Resident #1's admission nursing assessment, dated 2/15/13, documented an 82 year old male	F 314	F 314 Treatment/Svcs to Prevent/Heal Pressure Sores ● Resident #1's current treatment and plan of care related to pressure ulcer on his right heel was reviewed and coordinated with the attending physician at the wound clinic by the Director of Nursing or designee on or before April 30, 2013. The residents plan of care and orders were updated as needed. ● Resident's skin was assessed by an RN nurse manager on or before 4/30/13 with no new pressure ulcers identified. Residents were reassessed for pressure ulcer potential using the Norton + on or before 4/30/13 and their care plans were updated as needed ● Direct care staff will be re-educated by the staff development coordinator on or before April 30, 2013 regarding pressure ulcer		

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F 314	<p>Continued From page 27</p> <p>whose diagnoses included diabetes and hypertension. The assessment documented "drk [dark]scab" on Resident #1's right foot. Additionally, Resident #1's nursing notes, dated 2/15/13, documented "...heels intact. Has small black scab, hard/dry to [right] heel."</p> <p>Further, Resident #1's Admission MDS assessment, dated 2/22/13, documented Resident #1 did not present with any pressure ulcers, Stage 1 or higher.</p> <p>NOTE: During an interview on 3/28/13 from 9:55 - 10:15 a.m. with Medical Records Supervisor, and Care Coordinator person, the Care Coordinator person stated Resident #1 did not admit with pressure ulcers. She stated the black scab documented on 2/15/13 was not eschar or any other indication of a pressure ulcer.</p> <p>On 2/22/13, Resident #1's Pressure Ulcer Documentation Form documented an unstageable pressure ulcer measuring 6.5 cm x 3.75 cm on his right heel. No depth for the wound was recorded. A corresponding Change of Condition Documentation form stated "Res has developed a purple blister to [right] heel 3.75 cm x 6.5 cm. Blister has been covered [with] foam dressing and protective boot placed. Family notified. Will monitor until healed."</p> <p>Resident #1's record included physician's orders, dated 2/26/13, with instructions related to daily dressing for Resident #1's right heel pressure ulcer.</p> <p>NOTE: Physician orders for treatment were not obtained until 4 days after the pressure ulcer was</p>	F 314	<p>prevention, implementing pressure reducing devices, wound assessment and documentation.</p> <ul style="list-style-type: none"> Beginning the week of 4/30/2013 the Director of Nurses or designee will audit 3 random residents determined to be at risk for skin break down, to ensure proper interventions, and orders are in place, weekly for 4 weeks, then monthly for 2 months. The results of these audits will be reported to the Performance Improvement Committee monthly for 3 months or until resolved. The Director of Nursing is responsible for monitoring and follow up. April 30, 2013 		

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F 314	<p>Continued From page 28 first noted on 2/22/13.</p> <p>Resident #1's Interdisciplinary Progress Notes included an entry from nursing, dated 2/28/13, that stated "New stage II pressure ulcer to [right] heel. Daily treatments in place. New interventions in place [related to] pressure ulcer."</p> <p>NOTE: It could not be determined if this was a new pressure ulcer or if it was the ulcer that was documented as being "unstageable" on 2/22/13.</p> <p>There was no additional documentation indicating if the new interventions and daily treatments mentioned in the 2/28/13 note were new orders or if the entry was a delayed entry from the implementation of the 2/26/13 treatments.</p> <p>NOTE: It could be determined what the new interventions and treatments for Resident #1 were.</p> <p>An appointment note from a wound clinic visit, dated 3/13/13, documented Resident #1 was in "related to his right posterior ulcer on his right foot." Under the section titled Treatment, the note documented "swab the wound with Chloraprep, cover with Mepilex foam, Kerlix and place abdominal pad posterior heel and another Kerlix, medipore tape. Monday, Wednesday, Friday."</p> <p>Further, the note stated, "The nursing facility may continue dressings as above to his right foot and monitor it to make sure it does not deteriorate. Ideally, he should have offloading heel protectors. He is in a wheelchair that has a foam heel protector, however, his heels still rest in that type of foot foam rest. His bony prominences should</p>	F 314			

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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 03/29/2013
NAME OF PROVIDER OR SUPPLIER PAYETTE CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 3RD AVENUE SOUTH PAYETTE, ID 83661		
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F 314	<p>Continued From page 29 be assessed every 8 hours..."</p> <p>There was no documentation in Resident #1's record indicating that the dressing orders were implemented. Additionally, there was no documentation related to assessment of Resident #1 every 8 hours as recommended.</p> <p>Resident #1's record included Interdisciplinary Progress Notes with a nursing entry dated 3/14/13. The entry documented that Resident #1 was being discharged for surgery. At the time of discharge, Resident #1 had treatment orders, including a 2/26/13 Physician's Order with instructions for dressing changes, in place related to a pressure ulcer on his right heel.</p> <p>Resident #1's readmission Nursing Assessment, dated 3/17/13, documented Resident #1 returned with the pressure ulcer still on his right heel.</p> <p>During an interview on 3/28/13 from 9:55 - 10:15 a.m. with the DON, Regional Nurse Consultant, and MDS nurse, the Regional Nurse Consultant stated the facility did not receive any of Resident #1's wound clinic visit notes until 3/22/13. She stated they were unaware of any treatments given or prescribed by the wound clinic from the initial visit, 3/6/13, forward, due to the lack of dictation.</p> <p>NOTE: Refer to F514 for additional information regarding the wound clinic notes.</p> <p>Resident #1's 3/2013 MAR was revised to include an order for dressing changes to his right heel as follows:</p> <p>- change dressing to right heel daily (Mepilex)</p>	F 314			

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F 314	<p>Continued From page 30 secure with gauze</p> <p>The treatment was initialed for 3/25/13 and 3/26/13. However, the entry itself was undated and unsigned.</p> <p>Resident #1's care plan from his original admission date, 2/15/13, forward was requested from the MDS nurse. The care plan was provided and reviewed on 3/28/13 at 1:15 p.m. NOTE: The interventions identified below were undated and/or unsigned so it could not be determined when the interventions were implemented. Refer to F514 for additional information regarding the care plans.</p> <p>Resident #1's care plan included a section related to "Decreased mobility related to: Soft Tissue Injury, recent amputation of toes." The plan had an initiation date of 2/16/13 and a revision date of 3/18/13. The document had a print date of 3/21/13. The section included the following handwritten notes, listed in order:</p> <ul style="list-style-type: none"> - "New [wheelchair] " - "Prevelone [sic] boots " - "float heels when in bed" - "New cushion to [wheelchair] feet" - "3/4" "wound clinic weekly" This note was crossed out and had "D/C surgery 3/15" written below it. - "3/28" "Refer to wound clinic for [right] heel - [illegible initials]" <p>Resident #1's care plan included a section related to "Orthopedic Aftercare secondary to: Amputation to toes [illegible revision]-[non-weight bearing] to [bilateral] feet." The plan had an</p>	F 314			

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F 314	<p>Continued From page 31 initiation date of 3/18/13 and a print date of 3/21/13. The section included the following handwritten notes, listed in order:</p> <ul style="list-style-type: none"> - "3/21/13" "Provide splint per MD order" - "2/23" "Prevelone [sic] boots" - "float heels while in bed" <p>Resident #1's care plan included a section related to "Pain/Potential for pain related to: left diabetic foot ulcer with osteomyelitis." The plan included the following handwritten note:</p> <ul style="list-style-type: none"> - "3/21/13" "Provide position [changes] to assist [with decreased] pain as resident allows," unsigned <p>A dressing change for Resident #1's right heel pressure ulcer was observed on 3/26/13 from 12:55 - 1:30 p.m. Resident #1's pressure ulcer measured 7 cm x 4 cm with partially detached skin extending approximately 1 cm further around the wound. The wound had slight drainage, a dark circle in the center approximately 1 cm in diameter, with dark pink skin surrounding.</p> <p>NOTE: A second observation was conducted on 3/28/13 from 10:55 - 11:09 a.m. with a second surveyor with RN licensure. The wound was noted to have no depth and to be a Stage 2 pressure ulcer.</p> <p>Resident #1's record did not contain any documentation that the pressure ulcer was unavoidable.</p> <p>The facility failed to ensure Resident #1, admitted without pressure ulcers, did not develop pressure</p>	F 314		

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F 314	Continued From page 32 ulcers.	F 314			
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review it was determined the facility did not ensure residents were free from unnecessary anti-psychotic medication use. This was true for 1 of 3 residents (Resident #6) sampled for anti-psychotic medication use. The deficient	F 329	F 329 Drug Regimen is Free From Unnecessary Drugs <ul style="list-style-type: none"> ● Resident #6 discharged on 4/1/2013. ● An audit of residents on antipsychotic medications was completed on April 12, 2013 by the social worker, director of nurses and the consultant pharmacist, to ensure medication indications, documentation, behavior monitoring and gradual dose reduction monitoring were in place. Follow up was completed with the Physician as needed. ● Staff development coordinator to re-educate licensed nurses on care planning and thorough behavior monitoring documentation, documentation of non pharmacological interventions, and justification and documentation required for use of antipsychotic medication on or before April 30, 2013. Manager of Clinical Operations to re-educate the psychotropic committee (Social Services, Director of Nursing Services) on the use of antipsychotic medications, and obtaining justification from the provider, on or before April 30, 2013. ● Beginning the week of 4/30/2013 an audit of 3 residents on antipsychotic medication 		

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F 329	<p>Continued From page 33</p> <p>practice had the potential to cause more than minimal harm when a resident received an additional anti-psychotic medication without first having underlying medical causes ruled out, and without having attempted non-pharmacological intervention. Findings included:</p> <p>Resident #6 was admitted to the facility on 11/18/10 and re-admitted on 1/18/13, with diagnoses which included UTI, sepsis, dementia due to cerebrovascular disease, and insulin-dependent diabetes mellitus.</p> <p>On 1/25/13 Resident #6's Change of Condition MDS assessment coded: -BIMS of 8, indicating moderately impaired decision making skills. -No hallucinations or delusions. -No behavioral symptoms affecting others.</p> <p>On 2/6/13, Resident #6's Change of Condition MDS assessment coded: -Unable to complete the BIMS, staff assessment of moderately impaired decision making skills. -No hallucinations of delusions. -Verbal behavioral symptoms 1-3 days out of the past 7, but no overall behavioral changes.</p> <p>Resident #6's Active Orders (Recaps) for March 2013 included: -Clonidine Hcl 0.1 MG/24HR Patch Weekly for anxiety, started 1/18/13. -Clonazepam 0.125 mg one tab PRN daily, started 12/30/11 -Zoloft 100 mg daily for depression, started 11/18/10 -Abilify 7 mg daily for bipolar disorder, started 12/29/12</p>	F 329	<p>will be completed by the Director of Nursing or designee to ensure that the medication is necessary and has supporting documentation in place, including the use of non pharmacologic interventions weekly for 4 weeks and then monthly for 2 months. The results of these audits will be reported to the performance Improvement Committee monthly for 3 months or until resolved. The Director of Nursing is responsible for monitoring and follow up</p> <ul style="list-style-type: none"> • April 30, 2013 		

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F 329	<p>Continued From page 34</p> <p>-Haldol 2 mg twice per day for delirium, started 1/21/13</p> <p>-Prazosin Hcl 15 mg three tabs daily for PTSD, started 1/29/11</p> <p>NOTE: Resident #6 was admitted to the acute care hospital from 1/16/13 through 1/18/13, for a UTI with sepsis.</p> <p>Resident #6's Behavior Monthly Flow Sheet for January 2013 documented:</p> <p>-No instances of "Angry" noted.</p> <p>-No instances of "Depression" noted.</p> <p>-No instances of "Suspicious" noted.</p> <p>Resident #6's Behavior Monthly Tracking Flow Sheet for February 2013 documented:</p> <p>-One instance of "Angry" on each 2/1/13, 2/4/13 and 2/5/13. No other instances noted.</p> <p>-No instances of "Delusions" noted.</p> <p>-No instances of "Suspicious" noted.</p> <p>-No instances of "Nightmares" noted.</p> <p>-One instance of "Stories" noted on each 2/5/13, 2/9/13, and 2/22/13.</p> <p>NOTE: There was no documentation to define what "Stories" entailed as a behavior. There was no documentation addressing why Resident #6 had become "angry", or what was done to attempt to prevent or alleviate her anger.</p> <p>Beginning 1/18/13, on the date of re-admission to the facility from the acute care hospital, Resident #6's Interdisciplinary Progress Notes from the nursing staff documented:</p> <p>-1/18/13 at 8:45 PM, "A [and] O [alert and oriented] to self only...Res [Resident] lethargic all evening..."</p>	F 329		
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F 329	<p>Continued From page 35</p> <p>-1/19/13 at 1:15 PM, "Has been calling out [and] not using call light..."</p> <p>-1/19/13 at 8:55 PM, "A [and] O to self only. Voices needs although makes outlandish requests...verbally aggressive [with] staff, crying. Res calmed down upon the arrival of family..."</p> <p>-1/20/13 at 1:20 PM, "...abx [antibiotics] for UTI...Res pleasant [with] staff..."</p> <p>-1/20/13 at 9:20 PM, "...[No] behaviors this evening. Compliant [with] cares. [Elevated] BG [blood glucose level]."</p> <p>-1/21/13 at 10:30 AM, "Res cont [continues] abx [without] adverse reactions. Res cont to be confused, but improved from yesterday. MD notified about mental status. UA [urinalysis] ordered...[Psychiatric Nurse Practitioner] noted per MD request. New order for Haldol 2 mg BID. Will be re-evaluated next week when she [Psychiatric Nurse Practitioner] rounds..."</p> <p>Resident #6's Interdisciplinary Progress Notes from the Licensed Social Worker documented: -11/8/12, "[Resident #6] has done very well this month [with] only 2 episodes of suspiciousness noted...Mood has been stable..."</p> <p>-1/11/13, "[Psychiatric Nurse Practitioner] started Seroquel 12/27 but had a severe reaction so was D/C [discontinued] 12/29. [Resident #6] is still lethargic and staff question another stroke...Has had [sic] some issues of anger last month but easily redirected..."</p> <p>-2/15/13, "Readmitted from [acute care hospital] 1/18/13...Receiving Haldol now along [with] Abilify, Xanax PRN, Prazosin, Zoloft, [and] Clonazepam. Has been very angry, delusional..."</p> <p>The Psychiatric Nurse Practitioner's Progress Notes following the initiation of Resident #6's</p>	F 329			

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F 329	<p>Continued From page 36</p> <p>Haldol documented: 2/1/13, "Last month I tried switching [Resident #6] off Abilify to Seroquel...although she didn't tolerate it at all...so after one day we switched her back...She continued to exhibit symptoms of what sound [sic] like delirium, terribly confused, disoriented, and seeing things that were not there. The patient told me she had seen some rows of cotton growing outside the nursing facility...Continue current psychotropic medications..."</p> <p>NOTE: The progress note did not discuss the symptoms which led to the addition of Haldol for Resident #6, or an evaluation of whether or not the Haldol had been effective in addressing those symptoms. There was no documentation of the risks and benefits of the use of 2 anti-psychotic medications for Resident #6. There was no documentation of a plan to re-adjust Resident #6's psychotropic medications as her delirium resolved.</p> <p>On 3/27/13 at 9:40 AM, the DON, SDC, and Corporate Nurse Consultant were interviewed about the circumstances leading to the addition of Haldol for Resident #6 on 1/21/13, given that Resident #6 had been re-admitted from the acute care hospital only 3 days previously and was being treated for a UTI. The SDC stated Resident #6 had a history of paranoia and accusations towards staff, had always been followed by the Psychiatric Nurse Practitioner, and behavior monitoring was in place. The SDC described non-medication interventions in place as "We provide care in pairs." The SDC stated behavioral changes would be documented in the behavior flow sheets on the MAR, and in the social service progress notes. The DON, SDC, and Corporate</p>	F 329			

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F 329	Continued From page 37 Nurse Consultant stated Resident #6's physician had been notified of her mental status changes, as outlined in the nurse's progress noted, and the physician requested the Psychiatric Nurse Practitioner be consulted, and Haldol was started. They stated they would research the situation further and provide additional information. On 3/27/13 at 1:30 PM, the LSW was interviewed about Resident #6. The Social Worker stated Resident #6 has always been difficult to deal with due to bipolar disorder, vascular dementia, and a head injury at an early age. The LSW stated Resident #6 had a bad memory, and a history of false accusations and fluctuating between, "rude and angry, then smooth." The social worker stated Resident #6 tended to become angry when she was experiencing a UTI, and prior to her most recent hospitalization Resident #6 had been screaming and yelling at the staff. The LSW stated Resident #6 had been having delusions on 1/21/13 when the Haldol was started, but the delusions were not documented. The LSW stated she had questioned the Psychiatric Nurse Practitioner about the amount of Haldol ordered for Resident #6, and how long it would continue, but did not document those conversations.	F 329			
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days	F 387	F 387 Frequency & Timelines of Physician Visits ● Resident #6 discharged on 4/1/2013. Resident #5 was seen by Dr. Cabrera on 4/11/2013.		

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F 387	<p>Continued From page 38 thereafter.</p> <p>A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined residents were not seen by a physician at least once every 60 days. This was true for 2 of 6 residents (Resident #s 5 and 6) sampled for physician's visits. The deficient practice had the potential to cause more than minimal harm when Resident #6 was not seen by the physician between 10/19/12 and 1/10/13, then was admitted to the acute care hospital with a UTI and sepsis on 1/15/13. Findings included:</p> <p>1. Resident #6 was originally admitted to the facility on 11/18/10 and re-admitted on 1/18/13 with diagnoses including Cerebrovascular Dementia, Type 2 Diabetes, Hypertension, and Seizure Disorder.</p> <p>Resident #6's medical record did not document a physician's visit between 10/19/12 and 1/10/13, for a total of 83 days. On 1/15/13, Resident #6 was sent to an acute care hospital for evaluation. The hospital History and Physical, dated 1/16/13, documented diagnoses of metabolic encephalopathy, urinary tract infection with sepsis, high blood pressure, and acute kidney injury on chronic renal failure.</p> <p>2. Resident #5 was admitted to the facility on 1/26/11 with diagnoses including Bipolar Disorder</p>	F 387	<ul style="list-style-type: none"> ● Facility wide review of residents for timely physician visits was completed on 4/19/2013 by Health Information Management Coordinator. No current outstanding visits were identified. ● Education was provided to Health Information Management Coordinator by Nursing Home Administrator on physician visit requirements, tracking of MD visits and follow-up of non-compliant physicians on or before 4/30/2013. ● Beginning the week of 4/30/2013, 5 audits of MD visits/compliance will be completed weekly for 4 weeks, then monthly for 2 months, The results of these audits will be reported to the Performance Improvement Committee monthly for 3 months or until resolved. The Administrator is responsible for monitoring and oversight. ● April 30, 2013 		

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F 387	Continued From page 39 and Peripheral Vascular Disease. Resident #5's record did not document physician's visits between 6/20/12 and 9/27/12 (99 days), and again between 9/27/12 and 12/21/12 (85 days). On 3/27/13 at 4:30 PM, the Administrator, DON, and Corporate Nurse Consultant were informed of these findings. They stated the discrepancies had occurred when the facility was transitioning from one medical director to another. No further information was offered to resolve the concern.	F 387		
F 468 SS=E	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility did not ensure handrails were securely fastened. This was true for 1 of 2 hallways, 1 of 9 sample residents (Resident #1), and had the potential to effect any resident on the west hallway in the facility using the handrails. This deficient practice had the potential to cause more than minimal harm if a resident sustained a fall or injury from a loosened handrail. Findings included: On 3/25/13 at 9:55 AM, and 3/26/13 at 7:45 AM, the handrail in the west hallway outside the entrance to room 105, and the handrail in the west hallway between the nurse's station and the linen storage alcove, were noted to be loose.	F 468	F 468 Corridors Have Firmly Secured Handrails ● The handrails identified were repaired by the Director of Maintenance on 3/28/2013. Resident #1 was assessed by Director of Nurses or designee on or before April 30, 2013 and had no incident or injury related to use of loose hand rail. ● A review of center hand rails was completed by the maintenance director on 3/29/2013 with no further loose rails identified. The administrator reeducated the Director of Maintenance on 3/29/2013 ensuring that hand rails are well secured. Center staff were reeducated by the Administrator on filling out a maintenance	

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F 468	Continued From page 40 On 3/28/13 at 10:30 AM, during the environmental tour with the Maintenance Supervisor and the Administrator, the handrails in those locations were noted to still be loose. When the surveyor tugged lightly on the handrail between the nurse's station and the linen storage alcove, the handrail broke free from the wall. Two of the three brackets securing that handrail to the wall had severed in half. Part of the broken handrail was detached from the wall, while part was still fastened to the wall. The Administrator and Maintenance Supervisor were immediately informed of the surveyor's findings. The brackets were replaced and the handrail re-secured by 1:00 PM on 3/28/13.	F 468	request form if they identify that a handrail is loose on or before April 30, 2013. ● Beginning the week of April 30, 2013 the administrator will inspect the integrity of the hand rails, weekly for 4 weeks, then monthly for 2 months. The results of these audits will be reported to the Performance Improvement Committee monthly or until resolved. The Administrator is responsible for monitoring and follow up. ● April 30, 2013		
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 was determined the facility failed to ensure	F 514	F 514 Records-Complete/Accurate/Accessible ● 1.a. Resident #1's record was reviewed on 4/26/2013 by the Director of Nursing who clarified that the treatment on 2/26/13 was not changed on 2/28/13. The nurses note on 2/28/13 was describing the treatments initiated on 2/26/13. b. Resident #1's wound clinic documentation was requested by the Health Information manager on 03/22/2013 and Resident #1's current treatment plan was reviewed by the Director of Nursing on 03/29/2013 and current treatment plan was clarified with the wound clinic and the attending physician. Treatment is in place as ordered by MD		

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F 514	<p>Continued From page 41</p> <p>residents' clinical records were complete and accurate for 1 of 6 sample residents (Resident # 1). Failure to maintain complete and accurate medical records placed residents at risk for medical decisions based on incomplete or inaccurate information and at risk for complications related to inappropriate care. The findings included:</p> <p>1. Resident #1's admission Nursing Assessment, dated 2/15/13, documented he was admitted to the facility on 2/15/13 with diagnoses including diabetes and hypertension. Resident #1's record included a Pressure Ulcer Documentation Form, dated 2/22/13, that documented an unstageable pressure ulcer measuring 6.5 cm x 3.75 cm on his right heel.</p> <p>a. Resident #1's record included physician's orders, dated 2/26/13, with instructions related to daily dressing for Resident #1's right heel pressure ulcer. Resident #1's Interdisciplinary Progress Notes included an entry from nursing, dated 2/28/13, that stated "New stage II pressure ulcer to [right] heel. Daily treatments in place. New interventions in place [related to] pressure ulcer."</p> <p>There was no additional documentation indicating if the new interventions and daily treatments mentioned in the 2/28/13 note were new orders or if the entry was a delayed entry from the implementation of the 2/26/13 treatments.</p> <p>b. An appointment note from a wound clinic visit, dated 3/13/13, documented under the section titled Treatment, "swab the wound with Chloraprep, cover with Mepilex foam, Kerlix and</p>	F 514	<p>c. Resident #1's STAR's were reviewed by the Director of Nursing or Designee on 3/29/2013 for undated or signed entries with none noted.</p> <p>d.e.f. Resident #1's care plans were reviewed for appropriateness on 3/29/2013.</p> <p>2. Residents with current wound treatment plans including wound clinic documentation was requested to ensure updates and documentation was accessible in the medical record and reviewed by the Director of Nursing on or before 4/30/2013 and recommendations were reviewed against current treatment orders to ensure accuracy.</p> <p>Resident with wounds treatment records were reviewed for undated or signed entries on or before 4/30/2013 with none noted.</p> <p>Residents with wounds treatment orders, and care plans were reviewed, updated, and clarified with the physician as needed by the Director of Nursing or Designee on or before 4/30/2013.</p> <p>3. Licensed staff were reeducated by the Staff Development Coordinator on the process of processing and implementing physicians orders on or before 4/30/2013.</p>		

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F 514	<p>Continued From page 42 place abdominal pad posterior heel and another Kerlix, medipore tape. Monday, Wednesday, Friday."</p> <p>Resident #1's record did not contain any documentation indicating that the dressing orders were implemented.</p> <p>Additionally, Resident #1's MDS assessments, dated 3/15/13, did not include any information indicating physician's orders had been received in the past two weeks.</p> <p>During an interview on 3/28/13 from 9:55 - 10:15 a.m. with the DON, Regional Nurse Consultant, and MDS nurse, the Regional Nurse Consultant stated the facility did not receive any of Resident #1's wound clinic visit notes until 3/22/13. She stated they were unaware of any treatments given or prescribed by the wound clinic from the initial visit, 3/6/13, forward, due to the lack of dictation. The Regional Nurse Consultant stated she knew the Medical Records Supervisor had made attempts to obtain the visit notes, but did not know specifics of those attempts.</p> <p>When asked what efforts had been made to obtain the wound clinic visit notes, the Medical Records Supervisor stated during an interview on 3/28/13 from 10:32 - 10:40 a.m., she called for appointment notes one time per week. The weekly call was to obtain visit notes for all appointments from the previous week. The Medical Records Supervisor stated she did not document which offices she called each week. She stated the facility provided blank physician's order forms at each appointment and if any physician chose to write orders into their own visit</p>	F 514	<p>The Health Information Manager was reeducated verbally and in writing on 4/26/2013 by the Director of Nursing, pertaining to requesting dictation not received from the wound clinic or physician visit immediately following the appointment.</p> <p>4. Beginning the week of 4/30/2013 the Director of Nursing or designee will audit 3 residents going to the wound clinic for current medical record including requested dictation, implementation of physician orders, and updated plan of care weekly X4 weeks and then monthly X2 months. The results of these audits will be reported to the Performance Improvement Committee monthly or until resolved. The Director of Nursing is responsible for monitoring and follow up.</p> <ul style="list-style-type: none"> ● April 30, 2013 		

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

PRINTED: 04/15/2013
FORM APPROVED
OMB NO. 0938-0391

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F 514	<p>Continued From page 43</p> <p>notes as opposed to the form, she did not think that was the fault of the facility.</p> <p>c. Resident #1's 3/2013 MAR was revised to include an order for dressing changes to his right heel as follows:</p> <ul style="list-style-type: none"> - change dressing to right heel daily (Mepilex) secure with gauze <p>The treatment was initialed for 3/25/13 and 3/26/13. However, the entry itself was undated and unsigned.</p> <p>d. Resident #1's record included Interdisciplinary Progress Notes with a nursing entry dated 3/14/13. The entry documented that Resident #1 was being discharged for surgery. At the time of discharge, Resident #1 had treatment orders, including instructions for dressing changes, in place related to a pressure ulcer on his right heel.</p> <p>Resident #1's readmission Nursing Assessment, dated 3/17/13, documented Resident #1 returned with the pressure ulcer still on his right heel.</p> <p>Resident #1's care plan from his original admission date, 2/15/13, forward was requested from the MDS nurse. The care plan was provided and reviewed on 3/28/13 at 1:15 p.m.</p> <p>Resident #1's care plan included a section related to "Decreased mobility related to: Soft Tissue Injury, recent amputation of toes." The plan had an initiation date of 2/16/13 and a revision date of 3/18/13. The document had a print date of 3/21/13. The section included the following handwritten notes, listed in order:</p>	F 514		

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F 514	<p>Continued From page 44</p> <ul style="list-style-type: none"> - "New [wheelchair]," undated and unsigned - "Prevelone [sic] boots," undated and unsigned - "float heels when in bed," undated and unsigned - "New cushion to [wheelchair] feet," undated and unsigned - "3/4" "wound clinic weekly," unsigned. <p>Additionally, this note was crossed out and had "D/C surgery 3/15" written below it.</p> <ul style="list-style-type: none"> - "3/28" "Refer to wound clinic for [right] heel - [illegible initials]" <p>It was unclear how or why the care plan from Resident #1's 3/17/13 admission had handwritten notes from 3/15/13 and before.</p> <p>e. Resident #1's care plan included a section related to "Orthopedic Aftercare secondary to: Amputation to toes [illegible revision]-[non-weight bearing] to [bilateral] feet." The plan had an initiation date of 3/18/13 and a print date of 3/21/13. The section included the following handwritten notes, listed in order:</p> <ul style="list-style-type: none"> - "3/21/13" "Provide splint per MD order" - "2/23" "Prevelone [sic] boots," unsigned - "float heels while in bed," unsigned and undated <p>It was unclear how or why the care plan related to Resident #1's 3/18/13 admission had handwritten notes from 2/23/13.</p> <p>f. Resident #1's care plan included a section related to "Pain/Potential for pain related to: left diabetic foot ulcer with osteomyelitis." The plan had an initiation date of 2/16/13 and a revision date of 3/18/13. The section included the following handwritten note:</p>	F 514		

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F 514	Continued From page 45 - "3/21/13" "Provide position [changes] to assist [with decreased] pain as resident allows," unsigned The facility failed to utilize a system for obtaining complete and accurate records for Resident #1.	F 514			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001120	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/29/2013
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NAME OF PROVIDER OR SUPPLIER PAYETTE CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1019 3RD AVENUE SOUTH PAYETTE, ID 83661
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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.</p> <p>The following deficiencies were cited during the annual State licensure survey of your facility.</p> <p>The surveyors conducting the survey were:</p> <p>Nina Sanderson, LSW BSW Team Coordinator Patricia O'Hara, RN Ashley Anderson, QMRP</p>	C 000	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Payette Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p>	
C 147	<p>02.100.05,g Prohibited Uses of Chemical Restraints</p> <p>g. Chemical restraints shall not be used as punishment, for convenience of the staff, or in quantities that interfere with the ongoing normal functions of the patient/resident. They shall be used only to the extent necessary for professionally accepted patient care management and must be ordered in writing by the attending physician.</p> <p>This Rule is not met as evidenced by: Please see F 329 as it pertains to anti-psychotic medications.</p>	C 147	<p>C 147 Prohibited Uses of Chemical Restraints.</p> <p>Refer to F 329</p>	
C 389	<p>02.120.03,d Sturdy Handrails on Both Sides of Halls</p> <p>d. Handrails of sturdy construction shall be provided on both sides of all corridors used by patients/residents.</p> <p>This Rule is not met as evidenced by:</p>	C 389	<p>C 389 Sturdy Handrails on Both sides of Halls</p> <p>Refer to F 468</p>	

Bureau of Facility Standards

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

TITLE
Administrator

(X6) DATE

5-13-13

PRINTED: 04/19/2013
FORM APPROVED

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C 389	Continued From page 1	C 389		
	Please see F 468 as it pertains to loose handrails.			
C 409	02.120,05,i Required Room Closet Space	C 409	C 409 Required Room Closet Space	
	<p>i. Closet space in each sleeping room shall be twenty inches by twenty-two inches (20" x 22") per patient/resident. Common closets utilized by two (2) or more patients/residents shall be provided with substantial dividers for separation of each patient's/resident's clothing for prevention of cross contamination. All closets shall be equipped with doors. Freestanding closets shall be deducted from the square footage in the sleeping room.</p> <p>This Rule is not met as evidenced by: Based on staff interview, it was determined the facility did not provide the required closet space of 20 inches x 22 inches, for 1 of 3 halls (the 100 hall) in the facility. Findings include:</p> <p>On 03/28/2013, at 11:30 a.m., the administrator indicated that a waiver would again be requested for the closets. All the closets in rooms 101-120, and rooms 201 and 203 measured 36 inches wide and 22 inches deep. The closets that had dividers separating them, created individual closet space of 18 inches wide by 22 inches deep.</p>		<p>Waiver is requested.</p> <p>C 733 Frequency of Physician Visits</p>	
C 733	02.154,02,b Frequency of Physician Visits	C 733	Refer to F 387	
	b. Each skilled nursing patient shall be seen by the attending physician at least once every thirty			

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5/15/13

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C 733	Continued From page 2 (30) days for the first ninety (90) days following admission. Thereafter, an alternative schedule may be adopted for patient/ resident visits based on physician's determination of need, and so justified in the patient's/resident's medical record. At no time may visits exceed ninety (90) day intervals. All physicians' visits shall be recorded in the patient's/ resident's medical record, with a physician's progress note. This Rule is not met as evidenced by: Please see F 387 as it pertains to frequency of physician's visits.	C 733		
C 779	02.200,03,a,i Developed from Nursing Assessment i. Developed from a nursing assessment of the patient's/resident's needs, strengths and weaknesses; This Rule is not met as evidenced by: Please see F 272 as it pertains to completion of resident assessments.	C 779	C 779 Developed from Nursing Assessments Refer to F272	
C 782	02.200,03,a,iv Reviewed and Revised iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Please see F 280 as it pertains to care plan revisions.	C 782	C 782 Reviewed and Revised Refer to F 280	
C 788	02.200,03,b,iv Medications, Diet, Treatments as Ordered	C 788		

(Handwritten)
5-13-13

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C 788	Continued From page 3 iv. Delivery of medications, diet and treatments as ordered by the attending physician, dentist or nurse practitioner; This Rule is not met as evidenced by: Refer to F309 as it relates to the facility's failure to obtain physician orders prior to treating a wound.	C 788	C 788 Medications, Diet, Treatments as Ordered Refer to F 309
C 789	02.200,03,b,y Prevention of Decubitus v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for exercise to promote circulation; This Rule is not met as evidenced by: Refer to F314 as it relates to the facility's failure to prevent the development of a pressure ulcer and F281 as it relates to treatment of a pressure ulcer.	C 789	C 789 Prevention of Decubitus Refer to F 314 and F 281
C 881	02.203,02 INDIVIDUAL MEDICAL RECORD 02. Individual Medical Record. An individual medical record shall be maintained for each admission with all entries kept current, dated and signed. All records shall be either typewritten or recorded legibly in ink, and shall contain the following: This Rule is not met as evidenced by: Refer to F514 as it relates to accurate and complete medical records.	C 881	C 881 Individual Medical Record Refer to F 514

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5-13-13