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
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7012 1010 0002 0836 1741

April 8, 2014

Patty A. Goodwin, Administrator
Prestige Care & Rehabilitation - The Orchards
1014 Burrell Avenue
Lewiston, ID 83501-5589

Provider #: 135103

Dear Ms. Goodwin:

On **March 28, 2014**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Prestige Care & Rehabilitation - The Orchards by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies 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 sign both the 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 21, 2014**. Failure to submit an acceptable PoC by **April 21, 2014**, may result in the imposition of civil monetary penalties by **May 12, 2014**.

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 will you make to ensure that the deficient practice does not recur;

- How the corrective action(s) will be monitored to ensure the deficient practice does 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 have 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 (X5).

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

- The administrator must sign and date the first page of 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 2, 2014 (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 2, 2014**. A change in the seriousness of the deficiencies on **May 2, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **May 2, 2014** includes the following:

Denial of payment for new admissions effective **June 28, 2014**. [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 28, 2014**, 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 Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; 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.

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 28, 2014** 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:

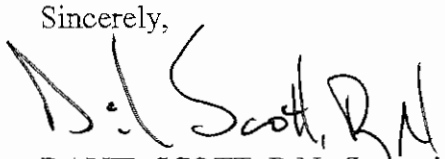
- BFS Letters (06/30/11)

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

This request must be received by **April 21, 2014**. If your request for informal dispute resolution is received after **April 21, 2014**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,



DAVID SCOTT, R.N., Supervisor
Long Term Care

DS/dmj
Enclosures

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

PRINTED: 04/04/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135103		03/28/2014

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following deficiencies were cited during the annual federal recertification and complaint survey of your facility. The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Amy Barkley, RN, BSN Becky Thomas, RN Jana Duncan, RN, MSN The survey team entered the facility on March 24, 2014 and exited on March 28, 2014 Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status CAA = Care Area Assessment CNA = Certified Nurse Aide DNS = Director of Nursing Services LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment POA = Power of Attorney PRN = As Needed RCM = Resident Care Manager	F 000	**F000 Initial Comments** "This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, **Prestige Care and Rehabilitation-The Orchards** 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."	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, it was	F 241	**F241** **Corrective Action/s for residents identified to have been affected:** **An interview of resident #16 was performed to ensure the residents dignity was not negatively affected by CNA #4 and LVN #1 conversation about the air plane. Resident stated that he was not affected or**	04/30/2014

RECEIVED
APR 21 2014
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE
Administrator 4/16/14

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.

Administrator 4/16/14

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F 241	Continued From page 1 determined the facility failed to ensure residents were treated with dignity and respect during their dining experience when staff ignored a resident while talking amongst themselves. This was true for one random resident (#16). This practice created the potential to negatively affect the resident's self-worth and self-esteem. Findings included: On 3/25/14 at 1:13 PM the surveyor entered the Dogwood Cafe Assisted Dining Room to find CNA #4 and LN #1 engaged in a conversation regarding problems with a particular airline. CNA #4 was observed assisting Resident #16 with his meal and LN #1 was seated next to Resident #16 but was not assisting any resident at that time. CNA #4 and LN #16 continued their conversation for two more minutes and did not engage the resident and ignored him while they discussed their airline issues. On 3/25/14 at 1:15 PM, LN #1 was interviewed regarding the observation. She confirmed the conversation was regarding an airline issue. When asked if the resident initiated the topic she stated, "No he didn't." On 3/25/14 at 1:20 PM, CNA #4 was interviewed regarding the observation. She confirmed the conversation was regarding an airline issue. When asked if the resident was involved in the conversation, she stated, "I don't know." When asked if they were talking with the resident or over the resident, she stated she was, "Not sure." On 3/25/14 at 3:55 PM, the Administrator and DNS were informed of the dignity issues. No further information was provided by the facility.	F 241	**disrespected during the conversation. There was no psychological harm.** **Identification of residents with the potential to be affected:** **Other residents have the potential to be affected by private conversations between staff, therefore current staff were re-educated to ensure compliance with meeting the dignity of the residents individually during meal times.** See Exhibit #1 **Measures to prevent recurrence:** **To prevent re-occurrence, Social Services Director or designee will conduct resident interviews no less than bi-weekly for 2 months, starting April 1, 2014. Then once monthly x 2 months to ensure compliance with this regulation.** **Monitor for Corrective Action:** **Copy of audit(s) with findings (negative outcomes/trends/patterns) will**	4-30-14

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F 247 F 247 SS=D	Continued From page 2 483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on record review, family interview, and staff interview it was determined the facility failed to provide advance notice before the resident received a new roommate. This was true for 1 of 9 (#5) sampled residents. This failed practice had the potential for psychosocial harm if the resident experienced increased anxiety, agitation, and/or fear. Findings include: Resident #5 was admitted to the facility with multiple diagnoses to include, Senile dementia with depression, COPD, and memory loss. The Resident's most recent Quarterly MDS, dated 2/18/14, documented the resident had severely impaired cognition. Note: Federal Regulation F 247, Interpretive Guidelines document, "For a resident who is receiving a new roommate, a staff member should give the resident as much notice and information about the new person as possible, while maintaining confidentiality regarding medical information." A typed time-line provided by the facility, dated 3/27/14 documented the following dates during which Resident #5 had a roommate (all different	F 247 F 247	**be provided to the Administrator for review and follow-up as necessary. The Administrator will present results to the Quality Assurance Performance Improvement (QAPI) committee to identify opportunities for performance improvement, monthly, x 3 months.** **F247** **Corrective Action/s for residents identified to have been affected:** **Resident #5 was assessed by DNS and was found to have no negative effects as a result of not receiving prior notice that she would be getting a new roommate.** **Identification of residents with the potential to be affected:** **Current residents, who have received new roommates or moved to another room within the past 3 months, have been**	4/30/14 4/30/14

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F 247	Continued From page 3 roommates): - 10/21/13 to 10/22/13, - 11/11/13 to 11/22/13, - 1/8/14 to 1/12/14, and - 2/28/14 to present. The Resident's, "Care Conference Report," dated 2/19/14, documented the family had concerns with the Resident having roommate, the facility explained the resident was in a semi-private room and would eventually have a roommate. The family stated that the family should be notified when a roommate is coming so they know someone will be sharing a room with Resident #5. During a family interview, on 3/26/14, at 10:30 AM, the family member (POA) stated that Resident #5 had had 4 different roommates and with each new roommate the facility failed to notify her. On 3/28/14, at 3:40 PM, the DNS was interviewed and stated she could not find any documentation the POA had been notified prior to the resident receiving the roommates. On 3/28/14, at 4:00 PM, the Administrator was interviewed and stated that she knew the resident had to be notified when the resident got a roommate, however, she did not know the facility had to notify the family as well. She stated the family had not been notified with each new roommate. No further information was provided to resolve the above issue.	F 247	**reviewed to ensure appropriate notification was completed.** See Exhibit #2 **Measures to prevent recurrence:** **Current management staff were re-educated on completion of the Notification of Roommate Change form prior to a change occurring. In the same respect it is noted that if the resident is not cognitive enough to understand, management was informed to notify family member with as much notice as possible prior to any room change or roommate acquisition.** See exhibit #3 **Monitor for Corrective Action:** **The Interdisciplinary Team (IDT)will review residents medical records for residents who received new roommates or where moved into another room to ensure appropriate notification was made during the morning stand up meeting, starting April 7, 2014** See exhibit #4	4/30/14
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment	F 279		

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F 279	Continued From page 4 to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure care plans were developed after the resident was admitted to the facility. This affected 1 out of 13 (#6) sampled residents. This failed practice created the potential for harm when residents' assessed needs were unmet due to lack of direction in the residents' care plans. Finding included: Resident #6 was admitted to the facility on 2/21/14 with diagnoses which included Septicemia, MRSA (Methicillin-resistant Staphylococcus Aureus), Septic Pulmonary Embolism, ESRD (End Stage Renal Disease) and Polyneuropathy.	F 279	**Results of these reviews will be forwarded to the Director of Nursing Services (DNS) for review and follow up if needed. The DNS will present findings to the Quality Assurance Performance Improvement (QAPI) committee to identify opportunities for performance improvement, Monthly x 3 months.** **F279** **Corrective Action/s for residents identified to have been affected:** **Resident #6 was assessed by Resident Care Manager for physical, mental and psycho-social affects and it was determined that no harm was created to resident #6, as a result of not having an identified infection included on the Comprehensive Care Plan (CPP). Resident #6's CPP has been updated.** See exhibit #5 **Identification of residents with the potential to be affected:**	4/30/14

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F 279	Continued From page 5 Record review of the Care Plan, with a date range of 2/21/14 - 3/25/14, did not contain evidence of a care plan for infections, i.e. MRSA, a bacteria which is resistant to many antibiotics, had a PICC (Peripherally Inserted Central Catheter) line, was taking IV antibiotics, was on contact precautions, or included measures to prevent transmission by direct or indirect contact with the resident or his environment. On 3/26/14 at 11:25 AM, RCM #6 was interviewed regarding the plan of care for infections. The RCM stated she did a preliminary care plan for MRSA on admission but neglected to put it on the actual care plan. On 3/27/14 at 4:45 PM, the Administrator and DNS were made aware of the findings. The facility provided no further information.	F 279	**Current residents care plans with this infection diagnosis have been reviewed. There were no other findings.** **Measures to prevent recurrence:** **Resident Care Manager's (RCM's) have been re-educated on including an infection diagnosis/problem on the CCP by the DNS or designee. Residents with infections will have their CCP reviewed by the RCM's and DNS at the daily MACC meeting, starting 4/7/14 Findings of these daily reviews will be tracked and trended by the DNS.** See exhibit #6 **Monitor for Corrective Action:** **The DNS will report results of CCP reviews to the QAPI committee to identify opportunities for performance improvement x 3 months.**	4/30/14
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 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. 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	F 280		

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			F280	
F 280	Continued From page 6 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. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, it was determined the facility failed to ensure the areas triggered by the RAI process were care planned as identified in the CAA and did not include input from the resident or their representative. This was true for 1 of 13 (#2) sampled residents for comprehensive care plans. This deficient practice created the potential for harm due to lack of direction in the care plan. Findings included: 1. Resident #2 was originally admitted to the facility on 7/25/07 and was readmitted on 1/17/13 with diagnoses which included Alzheimer's type dementia, depression, diabetes mellitus type II, and hypertension. The most recent Annual MDS Assessment, dated 1/19/14, documented in the CAA Detail Report for Visual Function: * The resident was moderately impaired with a checked box for "decreased visual acuity" under the section, "Review of Indicators of Visual Function"; * The "Supporting Documentation" section listed, "Face sheet, Assessment 01/21/2014"; and, * The "Functional limitations related to vision problems" section documented a checked box for "difficulty seeing television, reading material of	F 280	**Corrective Action/s for residents identified to have been affected:** **Resident #2 was assessed for negative effects due to failure to include Visual Function on the CCP and no harm to the resident was found. Resident's family has been notified of the change of condition of the resident. Resident has never worn glasses and is not showing signs of decreased visual acuity. Resident #2 care plan has been updated to include visual function assessment and interventions.** See exhibit #7 **Identification of residents with the potential to be affected:** **A review of the last 30 day CAA's detailed report for current residents, for visual function, was completed and there were no other findings.** See exhibit #8 **Measures to prevent recurrence:** **RCM's have been re-educated on including triggered CAA**	4/30/14

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F 280	Continued From page 7 interest, or participating in activities of interest because of vision problems." * The "Care Plan Considerations" section documented a box was checked "Yes" for Care Plan Decision. Review of the resident's medical record did not provide evidence of a care plan for Visual Function as identified on the CAA, dated 1/19/14. On 3/26/14 at 4:10 PM, when asked about the care plan for "Visual Function," RCM #5 stated the resident had never worn glasses and didn't know why the CAA triggered for vision. She stated the resident didn't have eye sight problems as a diagnosis. On 3/26/14 at 4:40 PM, the surveyor presented the CAA Detail Report for Visual Function to RCM #5 who witnessed the box was checked "Yes" for the Care Plan Decision, and stated it had not been care planned. Additionally, the Annual MDS Assessment triggered ten (10) CAA's which included: Cognitive Loss/Dementia, Visual Function, Communication, ADL Functional/Rehab Potential, Urinary Incontinence, Falls, Nutritional Status, Dental Care, Pressure Ulcers and Physical Restraints. With the exception of the Cognitive Loss/Dementia CAA, the area to provide input from the resident and/or representative for various care areas documented "None." On 3/27/14 at 10:20 AM, RCM #5 was asked about the expectations for the completion of the Family/Representative input for the triggered CAA areas. The RCM stated the CAA areas are covered in Care Conferences and, if the	F 280	**problems on the CCP by the DNS/ designee. For in house residents with visual function triggered, CAA's will be reviewed, by the RCM's and DNS at the daily MACC meeting, weekly X 1 month and monthly x 3 months starting 4/7/14.** See exhibit #9 & #10 **Monitor for Corrective Action:** **The DNS will track and trend the findings for the reviews and report the findings to the QAPI committee monthly x 3 months, to identify opportunities for performance improvement.**	4/30/14

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F 280	Continued From page 8 resident's guardian is around, they will call and address any concerns they have regarding the resident's care. The RCM stated they do not go over the plan of care of the CAA's with the resident's guardian. On 3/27/14 at 3:25 PM, the DNS was informed of the surveyor's concerns. The facility offered no further information.	F 280		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and family interview it was determined the facility did not ensure residents received baths as needed and scheduled. This was true for 2 of 9 residents (#5 and #14) sampled for ADL assistance. This created the potential for residents to experience discomfort, rashes or skin issues due to not being bathed regularly. Findings included: 1. Resident #5 was admitted to the facility with multiple diagnoses to include, Senile dementia with depression, COPD, overactive bladder, and memory loss. The resident's Admission MDS, dated 8/22/13, documented in part the following: - Severely impaired cognition,	F 312	**F312** **Corrective Action/s for residents identified to have been affected:** **Residents #14 has been dis charged from the facility. Resident #5 was assessed for skin impairments and no skin conditions were present.** **Identification of residents with the potential to be affected:**	4/30/14

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F 312	Continued From page 9 - Very important to choose between a tub bath, shower, bed bath, or sponge bath - Limited assist of one person for personal hygiene, and - Extensive assist of one person for bathing. The resident's most recent Quarterly MDS, dated 2/18/14, documented in part the following: - Severely impaired cognition, - Extensive assist of one person for personal hygiene, and - Total dependence of two people for bathing. The resident's ADL Care Plan, dated 9/5/13, documented in part the following, "[Resident's name] is to have shower/bath per facility shower schedule and prn." Note: The resident's ADL Care Plan did not document the resident's bathing preference, nor did it document the amount showers/baths or the days of the week the resident was to be bathed. Additionally, the care plan did not document what staff was suppose to do if the resident refused to be bathed; for example reapproach later, try different staff or different time of day. The resident's Point of Care, Daily Shower schedule, and Main shower list, documented the following related to the resident's baths/showers: * 1/2/14 - bed bath * 1/9/14 - shower * 1/16/14 - shower * 1/23/14 - shower * 1/30/14 - shower * 2/3/14 - 2 showers * 2/10/14 - shower * 2/13/14 - bed bath * 2/17/14- shower * 2/24/14 - Shower * 2/28/14 - refused * 3/3/14 - shower * 3/14/13 - refused * 3/16/14 - shower * 3/22/14 - shower * 3/23/14 - shower	F 312	**Current residents are being offered bathing/showers at least 2 times/week based on the residents preference.** **Measures to prevent recurrence:** **It was discovered during the survey process that the Point Of Care (POC) documentation system for residents was not coding bathing regularly by caregivers. Current Certified Nursing Assistants (NAC's) were re educated during the survey process on how to enter the information correctly when a resident has refused bathing instead of documenting "did not occur.** Exhibit #11 **In order to ensure the deficient practice does not re-occur, caregivers will follow the ADL care plan so that residents bathing preferences are honored during different time intervals of the day. NAC's will be re educated monthly and new employees will be educated upon hire on how to use the**	4/30/14

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F 312	Continued From page 10 * 2/20/14 - bed bath Note: After reviewing the above documented showers, it was determined the resident received only one shower a week for much of January, February, and March 2014. The DNS was interviewed on 3/27/14, at 4:20 PM. She was asked how the facility ensures residents are offered 2 showers a week. The DNS stated, all admits are placed on shower sheets for twice a week showers. Staff informed management if a resident requested showers on different days or a different shift, or more than twice a week. The DNS stated she was unable to find documentation to show the resident had or was offered showers twice a week and therefore she could not confirm whether or not the showers had occurred. 2. Resident #14 was admitted to the facility on 5/9/13 with multiple diagnoses including acute respiratory failure and rehabilitation procedures. Record review revealed the resident received only one shower in the eight days the resident resided at the facility. The resident received a shower on 5/12/13 and was discharged from the facility on 5/17/13. The Point of Care ADL Report for bathing reported the resident was totally dependent and needed extensive assistance of 2 persons to shower. On 3/27/14 at 11:55 AM, RCM #6 was interviewed and asked if the resident received more than one shower. When reviewing the ADL	F 312	**point of care system correctly by the Staff Development Coordinator (SDC) or designee. RCM's are monitoring point of care documentation for compliance with this requirement.** See exhibit #12 **Measures to prevent recurrence:** **Resident Care Mangers will ensure that each resident who enters the facility is placed on a bathing /shower schedule no less than 2 times a week, per the resident's preference. The RCM's will audit the POC documentation weekly X 4 weeks, bi-weekly x 1 month and monthly x 2 months for offers of bathing per residents preference, starting 4/7/14. Results of these audits will be forwarded to the DNS for review and follow up if needed.** **Monitor for Corrective Action:** **The DNS will report findings of the audits to the QAPI committee monthly x 3 months**	4/30/14

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F 312	Continued From page 11 Report, RCM #6 stated it looked like he only got one shower during his stay. On 3/27/14 at 4:45 PM, the Administrator was informed of the bathing issue. No further information was provided to resolve the above concern.	F 312	**to identify opportunities for performance improvement.**	4/30/14
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility did not ensure a urinanalysis and a catheter was only used when clinically indicated for 1 of 13 sampled residents (#9). This failed practice had the potential to cause urinary tract infections (UTI's) or other complications related to a catheter insertion procedure. Findings included: Resident #9 was admitted to the facility on 6/28/12 with multiple diagnoses including Huntington's disease and dementia without behavioral disturbances.	F 315	**F315** **Corrective Action/s for residents identified to have been affected:** **Resident # 9 currently does not have any clinical conditions that demonstrate a need for catheterization, and is catheter free. Assessment performed and resident #9 has not been harmed by having a female cathed urine specimen obtained. Physician notified of this regulatory requirement.** **Identification of residents with the potential to be affected:** **All physician orders have been reviewed for the appropriateness of a Fem cath and currently there are no residents in the facility with this order.** See exhibit #13 **Measures to prevent recurrence:**	

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F 315	Continued From page 12 The resident's quarterly MDS assessment dated 12/29/13, documented the resident did not have an indwelling catheter and was occasionally incontinent of bladder. The resident's Care Plan dated 10/10/12 documented a problem, "Resident experiences bladder incontinence R/T [related to] dx [diagnosis] of huntington's, and inability to toilet self." An approach dated 10/10/12 documented, "Report signs of UTI (acute confusion, urgency, frequency, bladder spasms, nocturia, burning, pain/difficulty urinating, nausea, emesis, chills, fever, low back/flank pain, malaise, foul odor, concentrated urine, blood in urine)." The resident's physician Progress Note dated 1/6/14, documented: "Apparently, she is not feeling well. Information is gained from the patient, although I have a difficult time understanding what it is she is telling me. There is a low-grade temperature today of 99.6...Because of a low-grade temperature, will have them get a UA [urinanalysis], C&S [culture and sensitivity] if indicated. I do not think she indicated any urinary tract infection-type symptoms. Unfortunately, her sister could not be here today and her sister helps a great deal with the translation of some of these issues." Note: Interpretive guidance at F 315 documented for those residents without an indwelling catheter should have at least three of the following symptoms before treatment for a UTI is to be considered: -Fever of 100 degrees or higher; -New or increased burning pain on urination, frequency or urgency; -New flank or suprapubic pain or tenderness;	F 315	**Licensed Nurses (LN's) have been re-educated on the CDC guidelines for preventing catheter related Urinary Tract Infections and symptoms that could indicate a UTI that should be reported to the Physician prior to receiving an order to obtain a urinalysis via catheterization by the SDC or designee. LN's will practice the standard of notifying the DNS or designee of any potential procedures with fem or straight caths prior to completing the procedure.** **RCM's and DNS will review new orders for any catheterization during the daily MACC meeting for appropriate diagnosis and the progress notes for documented signs and symptoms of UTI x 1 month, weekly x 1 month and monthly x 1 month, starting 4/7/14.** **The facility will use the interpretive guidance for those resident without an indwelling catheter that stipulate at least 3 of the following symptoms be present before treatment be considered –fever of 100 F or higher, increased burning or**	4/30/14

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F 315	Continued From page 13 -Change in character of urine (e.g., new bloody urine, foul smell, or amount of sediment; and, -Worsening of mental or functional status (e.g., confusion, decreased appetitive, unexplained falls, incontinence of recent onset, lethargy, decreased activity). Physician's Telephone Orders for the resident dated 1/6/14 documented, "UA C&S if indicated." In a Resident Progress Notes dated 1/7/14 at 8:44 PM, an LN documented, "Tried to obtain urine this shift, resident incontinent this shift, unable to obtain urine, will pass on to next shift, resident shows no s/s [signs or symptoms] of UTI sx [symptoms], afebrile. Resident responds "No" when this LN asked if she had pain or burning with urination. Will continue to observe." On 1/9/14 at 5:18 AM, a fax order request from the facility was sent to the resident's physician which documented, "We have been unsuccessful [at] obtaining UA clean catch. May we have orders to straight cath[eterization]?" At 12:49 PM, the order form was faxed back to the facility, was signed by the physician and documented, "Yes." Lab results for the resident dated 1/9/14, documented the resident did not have a UTI and a culture was not indicated. On 3/27/13 at 8:55 AM, the DNS was interviewed regarding the UA and straight catheter issue. When asked why the UA was ordered, she stated the physician, "Wanted to rule out UTI." When asked why the facility asked the physician to use a straight catheter, even though the facility had documented the resident did not have any signs and symptoms of a UTI, she said because the	F 315	**pain with urination, change in character of urine, worsening of mental of functioning status, pain or tenderness.** See exhibit #14 **Monitor for Corrective Action:** **The DNS will track and trend the findings of the daily reviews and report the findings to the QAPI committee monthly x 3, to identify opportunities for performance improvement.**	4/30/14

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F 315	Continued From page 14 physician had ordered it. On 3/27/14 at 4:45 PM, the Administrator and DNS were informed of the lack of medical justification for the UA and the catheter usage. No further information was provided.	F 315		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure harmful chemicals were secured in two unlocked closets. This was true for clean and soiled linen closets on 1 of 4 halls (300 hall). This failure created the potential for harm for any independently mobile, cognitively impaired resident who could access the unsecured chemicals. Findings included: On 3/25/14 at 10:55 AM, the clean linen closet next to resident room 307 was found to be unlocked. The top of the door near the frame had a bolt action type locking mechanism, but it was not engaged at the time of the observation. Inside on the shelf was a can of air freshener and was labeled, "Compressed gas: Flammable aerosol. Eye and skin irritant."	F 323	**F323** **Corrective Action/s for residents identified to have been affected:** **Air freshener was immediately removed from both un-locked closets during survey process. Staff were immediately re-educated on were to secure chemicals to prevent hazards.** See exhibit # 15 **Identification of residents with the potential to be affected:** **Other residents have the potential to be affected by the same deficient practice. Based**	4/30/14

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F 323	Continued From page 15 On 3/25/14 at 11:00 AM, RCM #2 was informed of the issue. She took the can out of the linen closet, locked the closet and stated, "I will take care of it." She then walked down the hallway with the can. On 3/25/14 at 11:02 AM, the soiled linen closet door next to resident room 305 was found without a lock on it. Inside on the shelf was an identical can of air freshener as above. On 3/25/14 at 11:04 AM, RCM #2 was informed of the additional hazard issue. She took the can out of the soiled linen closet and stated, "I will take care of these." On 3/25/14 at 3:55 PM, the Administrator and DNS were informed of the issue. No further information was provided.	F 323	**on observation rounds it was determined no residents were harmed by this deficiency.** **Measures to prevent recurrence:** **Current staff were re-educated that all chemicals, including air fresheners are to be secured in a locked closet or cabinet by the Maintenance Director or designee.** **Weekly environmental rounds will be performed by maintenance department staff to assure all hazardous chemicals are secured and behind a lock weekly x 1 month, bi-weekly x 1 month and monthly x 1 month starting 4/7/14.** **Results of the round will be forwarded to the Administrator for review and follow up. If needed.** See Exhibit #16 **Monitor for Corrective Action:** **The Administrator will report the findings of the environmental rounds audits to the QAPI committee, monthly x**	4/30/14
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it	F 328		

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F 328	Continued From page 16 was determined the facility did not administer CPAP (continuous positive airway pressure) and failed to obtain orders on admission for a resident who used CPAP regularly. Additionally, the facility failed to ensure the machine was in proper working condition. This was true for 1 of 3 residents (#14) sampled for respiratory care. These failures created the potential for the resident's respiratory condition to worsen and for the resident to experience increased sleepiness and lethargy during the day. Resident #14 was admitted to the facility on 5/9/13 with multiple diagnoses including acute respiratory failure - hypercapnic, organic obstructive sleep apnea - chronic, and discharged from the facility on 5/17/13. Record review documented a request for an order for CPAP, dated 5/9/13, "Resident also admitted with CPAP and no orders, could we please have orders for CPAP Q [use] every night?" An order was received on 5/10/13 from the physician for, "CPAP at noc [night]." NOTE: The order for CPAP did not include the liter flow needed. On 5/13/13 the resident's physician wrote an order, "1. C-PaP machine with 2 liters at HS [hour of sleep]" and "2. 2 liters oxygen PRN as needed for SOB [shortness of breath]." The Treatments Flowsheet documented the resident used the CPAP on 5/11, 5/12, 5/15 and 5/16, however, the ordered liter flow was not on the Treatment Flowsheet. Additionally, the Treatment Flowsheet did not contain the oxygen	F 328	**3 months, to identify opportunities for performance improvement.** **F328** **Corrective Action/s for residents identified to have been affected:** **Resident #14 has been discharged.** **Identification of residents with the potential to be affected:** **Current residents who have an order for a CPAP machine within the facility have been assessed and they have properly functioning units.** Exhibit #17 **Measures to prevent recurrence:** **LN's have been re-educated on the proper use and functioning of a CPAP machine and measures to take if one becomes**	4/30/14

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F 328	Continued From page 17 PRN order. A Progress Note dated 5/14/13 at 6:58 AM, documented, "Resident states he didn't wear C-PAP last night 'because a piece of tubing that connects the machine to an 02 source is missing'." On 5/15/13 at 3:59 AM, a Progress Note documented, "Resident states he didn't wear C-PAP again last night because that piece of tubing that connects the machine to an 02 source hasn't been brought from home by his wife." On 5/17/13 at 2:48 AM, a Progress Note documented, "C-PAP is currently in use as ordered." On 3/27/14 at 12:10 PM, LN #7 was interviewed. She stated the resident had his own CPAP machine and it was pre-set to the liter flow the resident used at home. She stated the CPAP was used by the resident on 5/11 and 5/12/13 and verified she was the nurse who signed the Treatment Flowsheet. On 3/27/14 at 2:55 PM, RCM #6 was interviewed and asked why it would take so long for the resident to have the CPAP. The RCM stated she wasn't sure and "if the staff knew about it on the 9th, they should have called for orders." When asked why the facility waited for the family to replace the missing piece to the CPAP, the RCM stated the facility's Central Supply should have supplied the missing piece. On 3/27/14 at 3:20 PM, the DNS was interviewed and told of the surveyor's concerns: 1) The delay in obtaining an order for CPAP; 2) The delay in	F 328	**dysfunctional by the SDC or designee.** **Treatment flow sheets are in place to assist nursing staff with directives on how to properly utilize CPAP machines and what measures to take should the CPAP become dysfunctional during use.** **RCM's or designee will monitor treatment flow sheets no less than 1x per week for documentation and equipment will be inspected to ensure it's in good repair, starting 4/7/14.** **RCM's will report findings to the DNS for review and follow up if needed.** **Medical Records (MR) will review monthly to ensure orders are in place and treatment is being provided without delay of care, starting 4/7/14.** **MR will report findings to the DNS for review and follow up if needed.** See Exhibit #18 **Monitor for Corrective Action:** **The DNS will report findings of the RCM's and MR's audits to the QAPI committee to identify**	4/30/14

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(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 328	Continued From page 18 replacing a missing piece; and, 3) The resident only used the CPAP for 4 out of the 8 days the resident was in the facility. The DNS stated the staff should have picked up the phone and called for an order. She stated, "I can see there was a delay of care there." On 3/27/14 at 4:45 PM, the Administrator was informed of the CPAP concerns. No further information was received from the facility.	F 328	**opportunities for performance improvement monthly, x 3 months.** **F356** **Corrective Action/s for residents identified to have been affected:** **No residents were identified.**	4/30/14
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 356	**Identification of residents with the potential to be affected:** **Daily Nursing hours are being posted daily in the front lobby of the facility.** **Measures to prevent recurrence:** **In order to ensure the deficient practice does not re-occur, all schedules are approved by DNS on a weekly basis and staff development coordinator reviews daily and posted by the entrance way daily for public observation.** **Monitor for Corrective Action:**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	135103		03/28/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	Continued From page 19 The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to display the nurse staffing posting in a prominent place readily accessible to residents and visitors. This affected 13 of 13 (#s 1-13) sampled residents and had the potential to affect all residents who resided in the facility and any visitors who came to the facility. Findings included: On 3/25/14 at 9:00 AM, the surveyor asked the DNS where the nurse staffing information was posted. The DNS took the surveyor into the employee break room and showed the surveyor the nurse posting on the wall. When asked if the posting was displayed in a public place as well, she shook her head in the negative and stated, "We used to." She said she would put a nurse posting up immediately. On 3/25/14 at 9:50 AM, the surveyor observed the nurse posting on the wall next to the front entrance to the facility. On 3/25/14 at 3:55 PM, the Administrator was informed of the issue.	F 356	**Staff development will monitor daily for 5 days x 2 weeks, then bi weekly x 4 weeks, then monthly. Administrator and/or DNS will oversee compliance and review in the monthly Quality Improvement meeting x 3 months, beginning April, 2014.** **F441** **Corrective Action/s for residents identified to have been affected:** **Resident #6, #17 and #18 have been assessed and no harm occurred to these residents because of lack of hand hygiene practices.** **Identification of residents with the potential to be affected:** **Current residents are receiving care and services by staff according to CDC guidelines for Hand Hygiene.** **Measures to prevent recurrence:**	4/30/14
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 20 safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and staff interview, it was determined the facility failed to	F 441	**Staff were re-educated on infection control practices and hand hygiene per CDC guidelines, including hand sanitizer when rendering care to a resident by the SDC or designee.** See Exhibit # 19 **The SDC will complete infection (IC) control rounds to identify any failed practice, weekly x 4 weeks, bi-weekly x 1 month and monthly thereafter, starting 4/7/14.** **The SDC will report findings to the DNS for review and follow up if needed.** **Monitor for Corrective Action:** **The DNS will track and trend IC rounds results and report findings to the QAPI committee to identify opportunities for performance improvement monthly x 3months.**	4/30/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 21 ensure standard precautions were used, including effective hand washing practices by staff: -Before direct resident contact; and -While providing peri-care for a resident with MRSA (Methicillin Resistant Staff Aureus), when the resident scratched both sides of his buttocks with both hands and did not receive hand hygiene. This was true for 1 of 13 sampled residents (#6) and a random resident observed for hand hygiene (#17). Failure to follow hand hygiene procedures placed residents at risk for infections. Findings include: The facility's Policy and Procedure on Hand Hygiene Revision, dated 10/2011, documented, in part: "The following is a list of some situations that require hand hygiene: ...Upon and after coming in contact with a resident's intact skin, (e.g. when taking a pulse or blood pressure, and lifting a resident)..." 1. Resident #17 was admitted to the facility on 1/8/14 with multiple diagnoses which included dementia and muscle weakness. On 3/26/14 at 11:25 AM, LN #1 was observed assisting resident #18 by pushing his wheelchair from his room down the hallway and into the dining room. LN #1 returned to the medication cart and found resident #17 standing near the cart outside the resident's room without shoes on. LN #1, took resident #17 by the hand and led her into her room, assisted resident with her shoes, then took the resident by the hand and led her into the dining room. The LN was observed without interruption in the dining room with	F 441		

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F 441	Continued From page 22 resident #18, in the resident #17's room from the doorway, and as she walked resident #17 into the dining room. No hand hygiene was observed for LN between resident #18 and resident #17, or after helping resident #17 with her shoes and taking her by the hand. Following the observation, LN #1 was questioned regarding hand hygiene. She said, "I washed between [the residents] in the room and just now with the sanitizer." However, hand hygiene was not observed by the surveyor before the LN assisted resident #17. 2. Resident #6 was admitted to the facility on 2/21/14 with diagnoses which included Septicemia, MRSA (Methicillin-resistant Staphylococcus Aureus), and Septic Pulmonary Embolism. On 3/25/14 at 9:55 AM, during an observation of wound care and peri-care, the resident was observed to scratch a large area of his left and right buttocks repeatedly using both hands. The DNS and RCM #6 both told the resident they would wash his hands when they were finished. On 3/25/14 at 10:25 AM, RCM #6 removed her gown and gloves, washed her hands per the facility's protocol and then left the room. The DNS followed the same protocol shortly thereafter and left the room without washing the resident's hands. When the DNS was asked by the surveyor if she was going to wash the resident's hands, the DNS stated, "Oh yes, I forgot, thanks for reminding me." On 3/27/14 at 4:45 PM, the Administrator and DNS were informed of the above infection control issues. No further information was provided by the facility.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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PRESTIGE CARE & REHABILITATION - THE ORCHARDS	1014 BURRELL AVENUE LEWISTON, ID 83501

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F 468 F 468 SS=E	Continued From page 23 483.70(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 failed to ensure all corridors were equipped with handrails. This affected 13 of 13 (#s 1-13) sampled residents and had the potential to affect other residents who frequented the corridors without handrails. This practice created the potential for residents to not have a handrail for stability when needed and had the potential to decrease quality of life if residents were not able to look out into a courtyard due to a lack of handrails near the windows. Findings included: On 3/25/14 at 8:00 AM, approximately 19 feet of handrails were observed to be missing on one side of the corridor from the Grove Lounge to the 300 hallway. The handrail was missing just below three windows where residents can look into one of the facility's courtyards. On 3/26/14 at 3:00 PM during the environmental tour, the Maintenance Supervisor was shown the missing handrails and was asked why handrails were not installed there and he stated, "I don't know why." He then stated, "That could be fixed." On 3/26/14 at 6:25 PM, the Administrator and DNS were informed of the issue.	F 468 F 468	**F468** **Corrective Action/s for residents identified to have been** **Resident's # 1 – 13 had no negative outcome from not having a handrail along the glassed wall in the corridor between the 2 resident units.** **Identification of residents with the potential to be affected:** **Resident #1-13 of sampled residents were all found to be in stable condition psychologically as a result of not being able to look out in to the court yard due to lack of a hand rail.** **Measures to prevent recurrence:** **Hand rail was installed 4/15/2014.** See exhibit #20 **Monitor for Corrective Action:** **Environmental director or designee will perform observation rounds weekly x2 weeks and then monthly (ongoing) to ensure new hand rail is in good working condition, starting 4/15/14.** **Administrator or designee will monitor monthly for compliance.** *All Auditing & tracking See exhibit #21	4/30/14

PRINTED: 04/04/2014
FORM APPROVED

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	MDS001760		03/28/2014

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	16.03.02 INITIAL COMMENTS 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. The following deficiencies were cited during the State licensure and complaint survey of your facility. The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Amy Barkley, RN, BSN Becky Thomas, RN Jana Duncan, RN, MSN	C 000	RECEIVED APR 21 2014 FACILITY STANDARDS	
C 125	02.100,03,c,ix Treated with Respect/Dignity ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; This Rule is not met as evidenced by: Refer to F241 regarding dignity issues during dining.	C 125	Please Refer to F241 for Plan of Correction	4/30/14
C 342	02.108,04,b,ii Toxics Stored Under Lock and Key ii. All toxic chemicals shall be properly labeled and stored under lock and key. This Rule is not met as evidenced by: Refer to F323 regarding chemical hazards in unlocked closets.	C 342	Please Refer to F323 for Plan of Correction	4/30/14
C 389	02.120,03,d Sturdy Handrails on Both Sides of Halls	C 389	Please Refer to F468 for Plan of Correction	

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

4/16/14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	MDS001760		03/28/2014

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

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

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C 389	Continued From page 1 d. Handrails of sturdy construction shall be provided on both sides of all corridors used by patients/ residents. This Rule is not met as evidenced by: Refer to F468 regarding missing handrails.	C 389	See F 468 For POC	4/30/14
C 670	02.150,03,a Aseptic/Isolation Techniques a. Applied aseptic or isolation techniques by staff. This Rule is not met as evidenced by: Please refer to F 441 regarding hand washing.	C 670	See F 441 For POC	4/30/14
C 778	02.200,03,a PATIENT/RESIDENT CARE 03. Patient/Resident Care. a. A patient/resident plan of care shall be developed in writing upon admission of the patient/resident, which shall be: This Rule is not met as evidenced by: Please refer to F-279 as it relates to Plans of Care.	C 778	See F279 For POC	4/30/14
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 refer to F-280 as it relates to Plans of Care.	C 782	See F 280 for POC	4/30/14
C 785	02.200,03,b,i Grooming Needs	C 785	Please See F 312 for POC	4/30/14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	MDS001760		03/28/2014

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

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

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C 785	Continued From page 2 i. Good grooming and cleanliness of body, skin, nails, hair, eyes, ears, and face, including the removal or shaving of hair in accordance with patient/resident wishes or as necessitated to prevent infection; This Rule is not met as evidenced by: Please refer to F312 as it relates to bathing.	C 785	See F312 FOR POC	4/30/14
C 788	02.200,03,b,iv Medications, Diet, Treatments as Ordered 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: Please refer to F-328 as it relates to Respiratory Care.	C 788	See F 328 FOR POC	4/30/14

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
PHONE 208-334-6626
FAX 208-364-1888

April 22, 2014

Patty A. Goodwin, Administrator
Prestige Care & Rehabilitation - The Orchards
1014 Burrell Avenue
Lewiston, ID 83501-5589

Provider #: 135103

Dear Ms. Goodwin:

On **March 28, 2014**, a Complaint Investigation survey was conducted at Prestige Care & Rehabilitation - The Orchards. Bradley Perry, L.S.W., Jana Duncan, R.N., Becky Thomas, R.N. and Amy Barkley, R.N. conducted the complaint investigation. This complaint was investigated in conjunction with three other complaints and the Recertification and State Licensure survey.

The following documents were reviewed:

- The identified resident's closed record;
- Bathing care plans and Point of Care Activities of Daily Living specific to shower documentation for nine (9) sampled residents;
- The Resident Council Meeting minutes from October 2013 to March 2014;
- Grievances from October 2013 to March 2014;
- The facility's Policy and Procedure for Respiratory Treatment;
- Follow-Up Survey Rounds 2013 dated May 21, 2013; and,
- Call Light Audit Log from March 11, 2013 to March 26, 2014.**

The following interviews were conducted:

- Quality of Life Assessment Group Interview on March 25, 2014, with five (5) residents in attendance; and
- Quality of Life Assessment Resident Interviews during the Recertification and State Licensure survey.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006071

ALLEGATION #1:

The complainant stated the resident was admitted May 9, 2013, and discharged May 17, 2013, and was planned for two (2) baths per week, Thursday and Sunday. However, the resident received only one bath in those eight days.

FINDINGS:

The identified resident's closed medical record documented the resident received only one shower in the eight days the resident resided at the facility. The facility was cited at F312 for failure to ensure residents received baths or showers as needed and scheduled.

CONCLUSIONS:
Substantiated. Federal and State deficiencies related to the allegation are cited.

ALLEGATION #2:

The complainant stated the resident needed help getting to the bathroom. The resident turned on his call light and waited for one hour and eleven minutes before staff responded. The complainant stated the resident had been incontinent of urine, soaking his bed, clothes and hair with urine. The complainant stated the resident routinely waited 30 minutes for the call light to be answered.

FINDINGS:

During the survey process, staff were observed to answer call lights in a timely manner. At the Resident Group Council Meeting on March 25, 2014, in which five (5) residents were present, the residents stated they didn't have any concerns with the facility's response time.

Residents were interviewed during the survey process and asked about any call light concerns or delays; they did not report any concerns.

Grievances were reviewed and did not reveal any call light concerns.

The Director of Nursing Services was interviewed on March 27, 2014, regarding the call light issue. The facility provided a Call Light Audit with a Log documenting an audit was conducted

for the last year from March 11, 2013 to March 26, 2014, at different times during the day. The audit log documented that the average length of time for response to call lights was between two to three minutes.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated the resident had a CPAP (continuous positive airway pressure) machine, but the facility never put it on him. The complainant stated the facility said the machine was broken due to a missing piece, and after it was repaired, the facility still never put the CPAP on him.

FINDINGS:

Review of the identified resident's closed record revealed the resident was admitted to the facility on May 9, 2013, and discharged from the facility on May 17, 2013. There was documentation of an order for CPAP dated May 10, 2013. Records reviewed documented the resident used CPAP on May 11, 2013 and May 12, 2013. However, progress notes documented the resident did not use CPAP on May 13, 2013 and May 14, 2013, due to a missing piece. Records reviewed documented the resident used CPAP on May 15, 2013 and May 16, 2013.

This allegation was substantiated and the facility was cited at F328.

CONCLUSIONS:
Substantiated. Federal and State deficiencies related to the allegation are cited.

ALLEGATION #4:

The complainant stated the family wanted to take the resident home and was told that if they took the resident home AMA (against medical advice), Medicare would not cover any of the facility's bill or the previous hospital's bill.

FINDINGS:

The identified resident's closed medical record documented an order to discharge the resident to home.

On March 27, 2014, the Director of Nursing Services was interviewed and asked how the facility

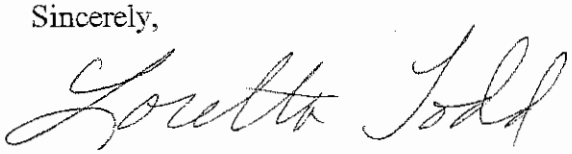
would respond to a resident who wished to leave AMA. She stated they would provide education on why it would be in the resident's best interest to finish their stay if it was for rehabilitation and then try to find the source of unhappiness and attempt to remedy any problems. When asked if they would ever say that Medicare would not cover any of the facility's bill or the previous hospital's bill, the Director of Nursing Services stated, "No, we have never been denied payment based on an AMA by Medicare."

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the complaint investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this complaint's findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,



LORETTA TODD, R.N., Supervisor
Long Term Care

LT/dmj

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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3232 Elder Street
P.O. Box 83720
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FAX 208-364-1888

FILE COPY

April 8, 2014

Patty A. Goodwin, Administrator
Prestige Care & Rehabilitation - The Orchards
1014 Burrell Avenue
Lewiston, ID 83501-5589

Provider #: 135103

Dear Ms. Goodwin:

On **March 28, 2014**, a Complaint Investigation survey was conducted at Prestige Care & Rehabilitation - The Orchards. Bradley Perry, L.S.W., Amy Barkley, R.N., Becky Thomas, R.N. and Jana Duncan, R.N. conducted the complaint investigation. This complaint was investigated in conjunction with the facility's annual Recertification and State Licensure survey conducted on March 24 through 28, 2014.

The following observations were conducted:

- The ceiling and hallway in the annex portion of the facility was observed each day from March 24 to March 28, 2014;
- Residents' care areas and every residents' room were observed for sewage back-up and smells on March 24, 2014, during the entrance tour and throughout the survey; and,
- The kitchen was observed for sewage back up and smells on March 24, 2014, during the entrance tour and on March 26, 2014, during food temperature and tray line observations.

The following documents were reviewed:

- The facility's grievance logs from October 2013 to March 2014;
- Resident Council meeting minutes from December 2013 to March 2014;
- The facility's Maintenance Work History Report from March 2, 2013 to March 24, 2014;
- Maintenance work orders for April 5, 2013 and August 16, 2013;
- A local plumbing work orders and invoices for January 23, 2014 and February 13, 2014;

- The entire medical record of an identified resident; and,
- The medical records of five residents with depression were reviewed.

The following interviews were conducted:

- Five residents were interviewed at a group interview regarding ceiling leaks, sewage back up and smells in the facility;
- Three individual residents were interviewed regarding building maintenance and smell issues;
- Two residents' family members were interviewed regarding building maintenance and smell issues;
- The Maintenance Supervisor was interviewed regarding ceiling leaks, sewage back up and smells in the facility; and,
- The Director of Nursing Services was interviewed regarding reporting of maintenance issues by staff to the maintenance department and residents' care issues.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006368

ALLEGATION #1:

The complainant stated the ceiling in the annex hallway leaked each time it rained, especially over the previous three weeks, or when snow melted. The facility had done nothing to repair the leak and only provided a bucket in the hallway, which was emptied when it filled up.

FINDINGS:

During the initial tour of the facility and after it rained on March 25, 2014, no leaks were found in the ceiling of the annex hallway.

The facility's grievance files and Resident Council meeting minutes did not reveal any mention of leaking ceilings or buckets in the hallway collecting water.

Maintenance Work Orders for April 5, 2013 and August 16, 2013, documented that a seal coating was applied around vent pipes and the roof itself.

Five residents were interviewed at a group interview regarding ceiling leaks and a bucket placed in the hallway to collect the water, and they stated they were not aware if these things happened.

Three individual residents were interviewed regarding building maintenance and they had no concerns in this area.

Two residents' family members were interviewed regarding building maintenance and they had no concerns in this area.

The Maintenance Supervisor was interviewed regarding ceiling leaks; he stated he was aware of the past ceiling leaks, which happened over a year ago, but he practiced preventative maintenance to make sure potential leaks were dealt with before they become an issue. He also stated that due to this awareness, he was able to detect a potential leak in August 2013 in the annex ceiling before any water leaked onto the floor.

Based on records reviewed and residents, family and staff interviews, it was determined the allegation could not be verified.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant stated sewage pipes had been clogged or broken for three weeks and caused sewage to back up in residents' care areas and the kitchen. Even after the repairs, the backups continued and the facility still smelled of sewage. The complainant stated a member of management was informed of the issues, but after two weeks, there was still no resolution to the sewage issues.

FINDINGS:

Residents' care areas and every resident's room were observed for sewage back up and smell on March 24, 2014, during the entrance tour and throughout the survey; no issues were noted.

The kitchen was observed for sewage back up and smells on March 24, 2014, during the entrance tour and on March 26, 2014, during food temperature and tray line observations; no issues were noted.

The facility's grievance logs from October 2013 to March 2014 were reviewed; no issues were documented.

Resident Council meeting minutes December 2013 to March 2014 were reviewed; no issues were documented.

The facility's Maintenance Work History Report from March 2, 2013 to March 24, 2014, was reviewed; no concerns were found.

A local plumbing work order and invoices for January 23, 2014 and February 13, 2014, documented that two separate plumbing lines were snaked and cleared on the same day an issue of clogs was discovered. The cause of clogs was due to grease build up. In the Job Description, section of both documents there was no mention of sewage coming from lines and into the facility.

Five residents were interviewed at a group interview regarding sewage back-ups and smells in the facility; they had no concerns in this area.

Three individual residents were interviewed regarding building maintenance and smell issues; they had no concerns in this area.

Two residents' family members were interviewed regarding building maintenance and smell issues; they had no concerns in this area.

The Director of Nursing Services was interviewed regarding staff reporting maintenance concerns to the maintenance department. She stated that she and her staff would either inform the maintenance supervisor directly or fill out a Maintenance Request form as soon as a concern arose.

The Maintenance Supervisor was interviewed regarding sewage back up and smells in the facility. He stated the facility had two separate clogged pipe issues, but there never were any sewage backups that flowed into residents' care areas or the kitchen. He said a local plumber was notified and resolved issues of clogged pipes on the same day the issues arose.

Based on records reviewed and residents, family and staff interviews, it was determined the allegation could not be verified.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The complainant stated an unnamed resident attempted to hang himself or herself. The complainant would not give any indication if this was due to the fault of the facility or if the facility was negligent regarding this issue.

FINDINGS:

The surveyors were able to determine the identity of the resident mentioned by the complainant. The resident was no longer residing in the facility at the time of the survey.

The entire medical record of the resident was reviewed, including an investigation conducted by the facility, which was sent to the Bureau of Facility Standards.

The medical records of five (5) residents with depression were reviewed; no issues were found.

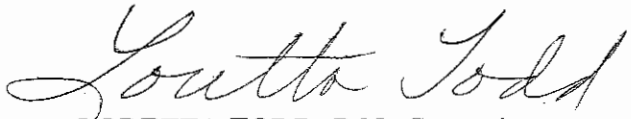
The Director of Nursing Services was interviewed regarding resident care issues, including mental health issues. She stated that the facility put in place appropriate interventions for the resident.

Based on records reviewed and staff interviews, it was determined the facility provided appropriate care for the identified resident and the allegation could not be verified.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

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

Sincerely,



LORETTA TODD, R.N., Supervisor
Long Term Care

LT/dmj

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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May 7, 2014

Patty A. Goodwin, Interim Administrator
Prestige Care & Rehabilitation - The Orchards
1014 Burrell Avenue
Lewiston, ID 83501-5589

FILE COPY

Provider #: 135103

Dear Ms. Goodwin:

On **March 28, 2014**, a Complaint Investigation survey was conducted at Prestige Care & Rehabilitation - The Orchards. Bradley Perry, L.S.W., Amy Barkley, R.N., Becky Thomas, R.N. and Jana Duncan, R.N. conducted the complaint investigation. This complaint was investigated during the facility's annual Recertification and State Licensure survey conducted on March 24, 2014 to March 28, 2014.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006392

ALLEGATION #1:

The complainant alleged the facility only had one shower room with two shower stalls and these had not been operational for "months."

FINDINGS:

During the environmental tour, six (6) shower rooms were identified with eleven working showers and/or bathtubs.

Grievances and Resident Council Meeting minutes were reviewed from October 2013 to present and did not document any concerns related to inadequate bathing facilities.

A resident group interview was conducted during the survey, and the residents in attendance stated they received two (2) showers a week and one (1) resident stated she had asked for an additional shower during the week and received it.

Three (3) residents and a family member were interviewed and did not verbalize any concerns related to inadequate number of bathing facilities.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The complainant had a concern related to the resident not receiving two showers weekly.

FINDINGS:

The following documents were reviewed:

- The identified resident's record along with the records of nine (9) other sampled residents;
- Grievances from October 2013 to March 2014;
- Resident Council Meeting minutes from October 2013 to March 2014;
- Bathing care plans for the identified resident along with bathing care plans for nine other sampled residents; and
- Point of Care Activities of Daily Living (ADL's) specific to shower documentation.

The Director of Nursing Services (DNS), Regional Nurse Consultant (RNC) and the Registered Nurse Care Manager (RNCM) were interviewed related to bathing practices at the facility. The RNC and DNS stated the facility did not have a specific policy for bathing. They both stated it was the facility's "Standard of Practice" to offer residents showers twice a week. The RNCM stated the resident was scheduled on the weekly shower list to receive two (2) showers a week. The RNCM stated she could not confirm whether or not the resident was actually being offered or receiving two (2) showers a week.

The records indicated the identified resident did not receive two (2) showers a week.

This allegation is substantiated and the facility was cited at F312 for failure to provide an adequate number of showers for the identified resident.

CONCLUSIONS:
Substantiated. Federal and State deficiencies related to the allegation are cited.

ALLEGATION #3:

The complainant had concerns related to:

- The resident missing money from their billfold;
- "Five hundred dollars" worth of clothing that "disappeared" and was not replaced by the facility; and
- A pair of shoes that went missing and was later found inside the nurses' station.

FINDINGS:

The following documents were reviewed:

- Grievances from October 2013 to March 2014;
- Resident Council Meeting minutes from October 2013 to March 2014;
- The identified resident's record along with nine (9) other sampled residents;
- The facility's policy related to "Resident personal items safekeeping;" and
- The facility's Admission Pack.

Grievances reviewed did not document the resident, nor any concerned party, had reported a loss of "five hundred" dollars worth of clothing to the facility. When a family member was interviewed related to missing clothes, he/she stated the facility had been notified of a loss and attempted to find the resident's missing clothes but were unsuccessful. The facility then asked the concerned party if he/she was able to replace the missing items, and if so, to bring in receipts for the clothes, and the facility would reimburse him/her for the cost of the new clothes.

The Business Office Manager (BOM) was interviewed related to the facility's policy for missing money and missing articles of clothing. She stated when a resident is admitted, the business office discusses the interest earning trust account with the resident and/or POA. The BOM stated if the resident and/or POA does not wish to use the trust account, the facility has them sign a form that states the trust account has been discussed with the resident and/or POA and it was declined. Additionally, each resident has a drawer in his or her nightstand that locks, and the resident is the only one with the key.

The Social Service Director (SSD) was interviewed and stated if a resident or resident's family member has concerns related to missing articles of clothing it is reported to laundry to look for it, staff looks in the closet of the roommate to ensure it didn't get placed in the wrong closet, staff then looks in every resident's closet on the unit of the resident who is missing the articles of clothing and finally the resident's inventory list is reviewed. The SSD stated if the articles of clothing are still missing, it is reported to her and she fills out a missing items form that is

distributed to all departments. Finally, if all attempts to the find the clothing have failed, the family is asked to replace the missing items if they can afford to do so and bring the receipts into the business office for reimbursement. If the family is unable to purchase the clothing first, the facility will make other arrangements with the family.

Additionally, the resident's shoes were found. If they had not been found the facility would have replaced them.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The complainant had a concern related to staff at the facility not wearing nametags.

FINDINGS:

Throughout the survey process March 24, 2014 to March 28, 2014, staff was observed to have facility provided nametags on.

A Resident Group meeting was conducted with six (6) residents present, and they did not verbalize any concerns related to staff not wearing nametags.

There are no state or Federal Regulatory requirements about staff wearing nametags; therefore, this complaint is considered a customer service concern.

CONCLUSIONS:
Unsubstantiated.

ALLEGATION #5:

The complainant had a concern related to a resident having "several" non-injury falls.

FINDINGS:

The following documents were reviewed:

- Grievances from October 2013 to March 2014;
- Incident and Accident Reports from October 2013 to March 2014;
- The identified resident's medical record, in addition to nine (9) other sampled residents;

- The facility's policy and procedure related to accidents/falls; and
- The resident's annual MDS dated August 22, 2013, and quarterly MDS dated February 18, 2014.

Incident Reports dated January 6, 2014, January 17, 2014 and February 19, 2014, were reviewed and documented the following:

- January 6, 2014, at 3:20 p.m., the resident was holding onto her wheelchair and bent over to pick up her "ring," the walker tipped forward and the resident fell. Neuro checks were started on the resident and she was started on alert charting. The resident was educated to ask for help from staff when she drops something and needs help picking it up.
- January 17, 2014, at 5:45 a.m., the resident was found on the floor in the bathroom doorway. The resident's nightgown was saturated and she stated, "(Person's name) came in here and knocked me down." The facility identified it was not the resident's usual behavior to be incontinent or to have visual hallucinations. The facility collected and tested a urine specimen to assist in ruling out possible Urinary Tract Infection. The resident was then placed on alert charting to monitor for increased signs and symptoms of Urinary Tract Infection.
- February 19, 2014, at 7:00 p.m., staff was within five feet of the resident's room when they heard a "thump." The resident was found sitting on the floor, between her bed and over-the-bed table. The facility determined this fall was related to the resident's decline in condition. The resident had episodes of decreased oxygen saturations and increasing fatigue with exertion. The resident was assessed by the nurse and found to have crackles in the lungs as well as a mildly elevated temperature. The resident was placed on neuro checks and every 15-minute checks. In addition, the resident had a chest X-ray done and was found to have "atelectasis or pneumonia." The resident was started on an antibiotic and breathing treatments, with a repeat X-ray scheduled on March 7, 2014.

The DNS and RNCM were interviewed related to the above falls. The DNS stated the family was notified with each fall, per the facility's protocol. After each fall, a root cause analysis was done to determine if there was a specific time of the day in which the resident was falling, what the resident was doing prior to the fall to determine a pattern or if the resident had an unmet need. It was determined that each fall happened related to a different set of events. The resident was placed on neuro checks after each fall, which required the resident to be checked on more frequently.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

The complainant had concerns related to the resident having three different roommates since August 2013. The complainant stated the resident was not notified prior to changes in roommates.

In addition, one of the roommates was observed by the resident's family member going through the identified resident's billfold, dressers drawers and bedding.

FINDINGS:

The following documents were reviewed:

- The identified resident's record;
- Grievances from October 2013 to March of 2014;
- Resident Council Meeting minutes from October 2013 to March 2014; and
- The facility's policy related to Notification of Room Change/New Roommate dated November 2011.

During an interview with a member of the resident's family, it was determined that on the day the facility was notified that a roommate was going through the resident's billfold, dresser drawers and bed; the facility reassigned the roommate to a different room.

The former roommate, who was reassigned to a different room, was observed by the surveyor from March 24, 2014 to March 28, 2014, to have a one-to-one staff member with her.

The facility failed to provide advance notice before the resident received a new roommate.

This allegation was substantiated, and the facility was cited at F247 for failure to notify the resident related to a new roommate or roommate change.

CONCLUSIONS:
Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #7:

The complainant had a concern related to the smoking area being "very" dirty with overflowing garbage containers and ashtrays.

FINDINGS:

The following documents were reviewed:

- Grievances from October 2013 to March 2014; and
- Resident Council Meeting minutes from October 2013 to March 2014.

A group interview was conducted with five (5) residents present, and they did not verbalize any concerns related to a dirty smoking area.

The designated smoking area was observed multiple times throughout the survey, from March 24, 2014 to March 28, 2014, without overflowing garbage cans or ashtrays.

On March 24, 2014, at 10:50 a.m. and 10:55 a.m., two (2) residents in the smoking area were asked if the smoking area was kept clean by staff or if they had to ask staff to clean it. The residents stated that staff is very good about keeping the ashtrays and garbage cans clean.

The DNS was interviewed related to the above concern and stated that all staff members from housekeeping, maintenance and nursing check the smoking area throughout the day to ensure it is kept neat and clean for the residents that smoke.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #8:

The complainant had a concern related to "Staff is rude to the smokers."

FINDINGS:

The following documents were reviewed:

- Grievances from October 2013 to March 2014; and
- Resident Council Meeting minutes from October 2013 to March 2014;

A Resident Group interview was conducted with five (5) residents present and the group stated none of them smoke, but they see staff helping residents outside all the time to smoke and are friendly about it.

Two (2) residents observed in the smoking area were interviewed related to how staff treats the

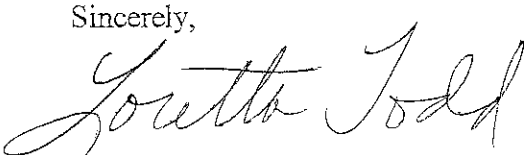
smokers. Both residents stated that staff is great, treat the smokers well and they have no issues.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the complaint investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this complaint's findings letter, as it will be addressed in the provider's Plan of Correction.

If you have questions, comments or concerns regarding our investigation, please contact Lorene Kayser, L.S.W., Q.M.R.P. or David Scott, R.N., Supervisors, Long Term Care at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,



LORETTA TODD, R.N., Supervisor
Long Term Care

LT/dmj

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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FILE COPY

April 8, 2014

Patty A. Goodwin, Administrator
Prestige Care & Rehabilitation - The Orchards
1014 Burrell Avenue
Lewiston, ID 83501-5589

Provider #: 135103

Dear Ms. Goodwin:

On **March 28, 2014**, a Complaint Investigation survey was conducted at Prestige Care & Rehabilitation - The Orchards. Bradley Perry, L.S.W., Amy Barkley, R.N., Becky Thomas, R.N. and Jana Duncan, R.N. conducted the complaint investigation. This complaint was investigated in conjunction with the facility's annual Recertification and State Licensure survey on March 24 through 28, 2014.

The following documents were reviewed:

- MARs for 23 residents;
- The facility's corporate investigation and conclusions of MAR inconsistencies dated January 13, 2014;
- The facility's investigation of MAR inconsistencies dated January 13, 2014;
- Grievances filed for the facility from October 2013 to March 2014; and
- Policies in place prior to January and afterwards regarding holes in MARs and TARs (Treatment Administration Record).

The following interviews were completed:

- The facility's administrator regarding the facility's and corporate's investigations;
- Director of Nursing Services (DNS) regarding MAR procedures; and
- Three licensed nurses (LN) regarding MAR procedures.

The following observations were completed:

- Six different LNs were observed during medication administration as they documented in the MAR.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00006415

ALLEGATION #1:

The complainant stated the facility falsified medical records when holes were filled in residents' MARs (Medication Administration Record) for the months of October and November 2013 and March 2014. The complainant stated the facility was informed of the issue.

FINDINGS:

Three LNs were interviewed regarding procedures and how holes in documentation were handled by the facility. They reported that it had not been an issue. They stated that no one else filled in blank spaces on their behalf.

The DNS was interviewed regarding this issue. She reported prior to January 2014, weekly and monthly audits were completed of MARs and TARs. If holes were found, the responsible staff member was contacted to fill in the holes with the appropriate response, and if they were unable to do so, the missing medication or treatment signature was treated as a medication error. The DNS stated she did not fill in holes in MARs and TARs when the documentation was missing.

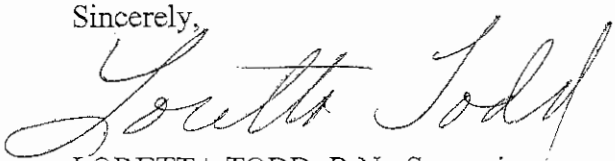
The Administrator was interviewed regarding the facility's investigation and conclusion; she stated she could not find any evidence of falsification of documentation. In addition, some holes were present during residents' MAR reviews.

It could not be confirmed that the facility falsified medical records and filled in holes for missed signatures in resident MARs. It was determined that the allegation could not be verified.

CONCLUSIONS:
Unsubstantiated. Lack of sufficient evidence.

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

Sincerely,



LORETTA TODD, R.N., Supervisor
Long Term Care

LT/dmj