



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 1628

June 5, 2014

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

Provider #: 135015

Dear Ms. Henderson:

On **May 9, 2014**, a Recertification, Complaint Investigation and State Licensure survey was conducted at Payette Center 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 an isolated deficiency that constitutes actual 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.) **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.

Shelly Henderson, Administrator  
June 5, 2014  
Page 2 of 4

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 **June 18, 2014**. Failure to submit an acceptable PoC by **June 18, 2014**, may result in the imposition of civil monetary penalties by **July 8, 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).

Shelly Henderson, Administrator  
June 5, 2014  
Page 3 of 4

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*.

This agency is required to notify CMS Region X of the results of this survey. We are recommending that CMS impose the following remedy:

**Denial of payment for new admissions effective as soon as notice requirements can be met. [42 CFR §488.417(a)]**

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **November 9, 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, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

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>

Shelly Henderson, Administrator  
June 5, 2014  
Page 4 of 4

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 **June 18, 2014**. If your request for informal dispute resolution is received after **June 18, 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,

A handwritten signature in black ink that reads "D. Scott, R.N." The signature is written in a cursive style with a large initial "D" and "S".

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

DS/dmj  
Enclosures

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 05/09/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  PAYETTE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1019 THIRD AVENUE SOUTH PAYETTE, ID 83661
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the annual federal recertification survey of your facility.</p> <p>The surveyors conducting the survey were: Rebecca Thomas, RN, Team Coordinator Amy Barkley, RN, BSN</p> <p>The survey team entered on May 5, 2014 the facility and exited on May 9, 2014</p> <p>Survey Definitions: ADL = Activities of Daily Living BIMS = Brief Interview for Mental Status cm = Centimeters CNA = Certified Nurse Aide CVA = Cerebral Vascular Accident CP = Care Plan DON = Director of Nursing H&amp;P = History and Physical I &amp; A = Incident and Accident LN = Licensed Nurse LPM = Liters per Minute MAR = Medication Administration Record MCO = Manager of Clinical Operations MD/md = Medical Doctor MDS = Minimum Data Set assessment MRSA = Methicillin-resistant Staphylococcus aureus NA = Not Applicable NPE = Nurse Practice Educator O.T. = Occupational Therapy PRN = As Needed P.T. = Physical Therapy ROM = Range of Motion r/t = related to</p>	F 000	<p style="text-align: center;"><b>RECEIVED</b></p> <p style="text-align: center;">JUN 18 2014</p> <p style="text-align: center;"><b>FACILITY STANDARDS</b></p> <p>“This Plan of Correction is prepared and submitted as required by law. By submitting this plan of correction Payette Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.”</p>	
-------	---	-------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *See Noel Administrator* TITLE *2017/14* (X6) DATE

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.

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/09/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>
---	---

(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	Continued From page 1 s/p = status post s/sx = signs and symptoms TAR = Treatment Administration Record tx = Treatment w/c = wheelchair	F 000		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS  The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.  The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).  The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.  The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance	F 225	F225  1. Residents affected  Resident #1 was assessed by the licensed nurse on 6/6/14. Resident with no adverse effect noted.  Resident #1's incident and accident reports for falls that occurred on 2/5/14, 2/2/14, and 1/28/14 were updated and closed by the Director of Nursing or designee on or before 6/13/14.  Resident #4 was assessed by a licensed nurse on 5/21/14 with no signs or symptoms of abuse noted.  Resident #4's incident and accident reports for falls that occurred on 3/23/14, 1/3/14, 12/7/13, 11/7/13, 10/30/13 were reviewed, updated, and closed by the Director of Nursing or designee on or before 6/13/14.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/09/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>		
(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 225	<p>Continued From page 2</p> <p>with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, and it was determined the facility did not complete investigations of incident and accident allegations within the required five (5) working day time frame for 2 of 6 residents (#'s 1 &amp; 4) sampled for incident investigations and at least forty-two RMS [Incident/Accident] reports still open and incomplete. This deficient practice had the potential for more than minimal harm and placed residents at risk for further abuse, neglect or mistreatment. Findings include:</p> <p>The facility's Accidents, Incidents, and Adverse Events Policy, dated 6/1/96 and revised on 9/1/13, documented the facility would "within 30 days of the occurrence of an adverse event, or of learning of such an event, Centers will complete a thorough root cause analysis, including associated process improvement actions as indicated."</p> <p>1. Resident #1 was admitted to the hospital with multiple diagnoses to include chronic airway obstruction, CHF (Congestive Heart Failure), A-fib (Atrial Fibrillation), and anemia.</p> <p>An Incident/Accident Report (I&amp;A), initiated on 2/5/14 at 8:55 AM, related to a fall was documented as "not complete" as of 5/9/14. This was 93 days after the fall occurred and the I &amp; A</p>	F 225	<p>2. Other residents with the potential to be affected.</p> <p>A review of incident and accident reports completed in the last 120 days were reviewed by the Administrator and Director of Nursing on or before 6/18/14 to ensure that they were complete, and closed.</p> <p>3. Systemic change</p> <p>The center Administrator and Director of nursing were educated on the policy for investigating and closing event reports by the Manager of Clinical Operations on 6/16/14.</p> <p>Incident and accidents will be reviewed each morning during stand-up by the interdisciplinary team.</p> <p>Department managers and licensed nurses were educated on the policy for investigating and closing incident and accident reports by the Director of Nursing or Designee on 6/25/14.</p>	

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>05/09/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>	
(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 225	<p>Continued From page 3 had been initiated.</p> <p>NOTE: Resident #1 had documented falls on 1/28/14, 2/2/14, and 2/5/14.</p> <p>2. Resident #4 was admitted to the facility on 10/25/13 and re-admitted on 3/28/14 with multiple diagnoses to include aftercare for fall with fracture, recent CVA, left-sided hemiplegia and expressive aphasia.</p> <p>The resident's Incident/Accident reports were reviewed and documented the following:</p> <ul style="list-style-type: none"> <li>- I&amp;A initiated on 10/30/13 at 4:45 PM, related to a fall was not completed until 5/12/14, 194 days after the fall.</li> <li>- I&amp;A initiated on 11/7/13 at 3:15 PM, related to a fall was not completed until 5/12/14, 186 days after the fall.</li> <li>- I&amp;A initiated on 12/7/14 at 7:00 PM, related to a fall was not completed until 12/23/13, 16 days after the fall.</li> <li>- I&amp;A initiated on 1/3/14 at 1:30 PM, related to a fall was not completed until 5/7/14, 124 days after the fall.</li> <li>- I&amp;A initiated on 2/5/14 at 9:00 AM, related to a fall was not completed until 5/7/14, 91 days after the fall.</li> <li>- I&amp;A initiated 3/23/14 at 10:00 PM, related to a fall was not completed until 4/1/14, 9 days after the fall.</li> </ul> <p>Note: The resident was transported to the hospital on 3/23/14 after the fall and was diagnosed with a left hip fracture which required surgical fixation.</p> <p>On 5/9/14, at 12:00 PM, the DNS, MCO, and SDC were interviewed related to the above</p>	F 225	<p>4. Ongoing Audits</p> <p>Beginning the week of 6/25/14 a review of 3 incident and accident reports will be completed by the Director of Nursing or designee to ensure that incident and accidents are investigated and closed timely. These audits will be completed weekly X4 weeks and then monthly X 2 months or until resolved. The results of these audits will be reported to the Performance Improvement Committee for review monthly or until resolved with remedial measures implemented as needed. The Director of Nursing is responsible for monitoring and follow-up.</p> <p style="text-align: right;">6/25/14</p>

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/09/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>
---	---

(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 225	Continued From page 4 concerns. The MCO stated that on 12/9/13 she and the RVP identified concerns related to Incident and Accident reports being completed and closed within 5 days of the event. On 12/9/13 the RVP and MCO identified forty-two RMS [Incident/Accident] reports still open and incomplete. The MCO stated the facility was going through the I&A's and completing those still open. No further information was provided to resolve this concern.	F 225		
F 241 SS=D	<p><b>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</b></p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on resident interview and group interview it was determined the facility did not ensure an environment to maintain or enhance dignity and respect was provided to all residents. This was true for 3 of 4 residents in the group interview. This deficient practice had the potential to cause more than minimal harm when residents had to wait longer than 25 minutes for staff to assist them to the bathroom, became agitated when incontinent, or became embarrassed at soiled clothing related to incontinence. Findings included:  On 5/7/14 at 11:00 AM, during the group interview, the residents were asked by the surveyors if they ever had to wait longer than 30 minutes to be assisted to the bathroom. The</p>	F 241	<p><b>F 241</b></p> <p>Residents affected</p> <p>No residents were identified.</p> <p>CNA staff was educated by the Director of Nursing or designee on 6/25/14 timely response to call lights and meeting residents needs including that they are to ensure that residents are neat and clean.</p> <p>A resident council/ group meeting was held by MSW on 6/19/14 to review resident dignity including call light response times, and ensuring that their needs are met timely. Follow up was completed for issues identified by MSW during the resident council meeting.</p>	

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 05/09/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  PAYETTE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1019 THIRD AVENUE SOUTH PAYETTE, ID 83661
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 241 Continued From page 5  
following statements were made:  
- "I use my call light, the CNA comes into the room turns it off and states he /she will be back in a few minutes to help me. I have to wait another 20-25 minutes during the day and night before I get the help I need."  
- "I use my call light, the CNA comes into the room, turns my call light off, states he/she will be back soon. I have to wait a long time and sometimes the CNA doesn't come back."  
- "There have been several times when I have put my call light on, the CNA responded, and said he/she will be back and then doesn't come back."  
The resident stated by the time the CNA or another CNA returns the resident has voided in her pants, which upsets her.

NOTE: One of four residents that participated in the group interview stated, "Since the 'State' had been in the facility this week things were much better." The CNAs were answering the call lights more promptly, meals were being served on time, and there was more staff. Two additional residents agreed with the statements made above. Three of the four residents in attendance at the group interview wished to remain anonymous.

F 241

2. Other residents with the potential to be affected.

Resident interviews and observations will be completed by the Administrator or designee on or before 6/25/14 to ensure that residents were neat and clean and cared for in a timely manner.

3. Systemic Change

Center staff will be educated by the Nurse Practice Educator on or before 6/25/14 related to resident dignity including the timely response of call lights and resident needs, and ensuring that residents are neat and clean

F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  
SS=D

The resident has the right, unless adjudged incompetent or otherwise found to be

F 280

6A

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 05/09/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  PAYETTE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1019 THIRD AVENUE SOUTH PAYETTE, ID 83661
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 241 Continued From page 5  
following statements were made:  
- "I use my call light, the CNA comes into the room turns it off and states he /she will be back in a few minutes to help me. I have to wait another 20-25 minutes during the day and night before I get the help I need."  
- "I use my call light, the CNA comes into the room, turns my call light off, states he/she will be back soon. I have to wait a long time and sometimes the CNA doesn't come back."  
- "There have been several times when I have put my call light on, the CNA responded, and said he/she will be back and then doesn't come back."  
The resident stated by the time the CNA or another CNA returns the resident has voided in her pants, which upsets her.

NOTE: One of four residents that participated in the group interview stated, "Since the 'State' had been in the facility this week things were much better." The CNAs were answering the call lights more promptly, meals were being served on time, and there was more staff. Two additional residents agreed with the statements made above. Three of the four residents in attendance at the group interview wished to remain anonymous.

F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO  
SS=D PARTICIPATE PLANNING CARE-REVISE CP

The resident has the right, unless adjudged incompetent or otherwise found to be

F 241  
  
4. Ongoing Audits  
  
Beginning the week of 6/25/14, 5 residents will be interviewed/ audited by the Administrator or designee to ensure that received care in a timely manner and that their personal needs were met weekly X4 weeks and then monthly X2 months. The results of these interviews/ audits will be reported to the Performance Improvement Committee for review X3 months or until resolved with remedial measures implemented as needed. The Administrator is responsible for monitoring and follow-up.

6/25/14

F 280

LB

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>05/09/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>
---	---

(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 280	Continued From page 6 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 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 medical record review it was determined the facility failed to ensure residents' care plans were periodically reviewed and revised when the residents' needs, goals, and conditions changed. This was true for 3 of 9 (#s 2, 4, & 5) sample residents. The deficient practice had the potential to harm residents if care needs were not identified and met. Findings include:  1. Resident #2 was admitted to the facility with multiple diagnoses to include abnormality of gait, muscular wasting and disuse atrophy, and intellectual disabilities.  The resident's most recent Quarterly MDS, dated 3/31/14, coded:	F 280	F280  Residents affected  Resident #2 was assessed by the RN on 6/5/14 with no adverse effects noted.  Resident #2's care plan was reviewed and updated by the MDS nurse on 6/13/14 to reflect the resident's current plan of care including the level of supervision that the resident requires, and the discontinuation of side rails, and wound care.  Resident #4 was assessed by a licensed nurse on 6/17/14 with no adverse effects noted.  Resident #4's care plan was reviewed and updated by the MDS nurse on 6/17/14 to reflect the resident's current plan of care including current weight bearing status.	
-------	---	-------	--	--

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/09/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>		
(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 280	<p>Continued From page 7</p> <ul style="list-style-type: none"> <li>- Short Term/Long Term memory impairment.</li> <li>- Moderately impaired ability for daily decision making.</li> <li>- Restraint in bed, bed rails - "none."</li> </ul> <p>The resident's Fall CP, dated 10/16/13, documented, "frequent room checks, and side rails up x 2 while in bed as an enabler." The CP did not document specific time parameters for the frequent checks and the resident did not have side rails on his bed.</p> <p>The resident's Nutrition CP, dated 10/18/13, documented, a Focus Area of cellulitis/abscess to the left foot. The Area had a line written through it and the written word, "resolved." It could not be determined when the cellulitis/abscess resolved as there was no date.</p> <p>The resident's Restorative Therapy CP, dated 4/29/14 documented, "Passive/Active ROM to extremity," however the CP did not identify which extremity, how many days of the week, or the amount of time each day this was to occur.</p> <p>The resident's bed was observed at numerous and various times of day from 5/5/14 - 5/8/14 from 8:00 AM in the morning to 3:00 PM without side rails.</p> <p>On 5/9/14 at 9:20 AM, the MCO, DNS, and SDC were interviewed related to the care plan concerns. The MCO stated she had added the Passive/Active ROM to the resident's CP on 4/29/14 and forgot to include which extremity, days per week, and amount of time each day. She stated she wasn't sure what the time parameters were for the frequent room checks or whether the checks were occurring. Additionally,</p>	F 280	<p>Resident #5 was assessed by the licensed nurse on 6/10/14 with no adverse effects noted.</p> <p>Resident #5s care plan was updated by the MDS nurse on 6/10/14 to reflect the resident's current plan of care.</p> <p>2. Other residents with the potential to be affected</p> <p>A review of resident care plans will be completed by the Director of Nursing or designee on or before 6/25/14 to ensure that they reflect the current level of care and services provided.</p> <p>3. Systemic Change</p> <p>Staff will be re-educated on or before 6/25/14 on ensuring that the care plan reflects the residents care and services provided.</p>		

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/09/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>
---	---

(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 280	<p>Continued From page 8</p> <p>the MCO stated she was unsure when the cellulitis/abscess had resolved, but knew the resident no longer had it. The surveyor asked the MCO why the resident's care plan had not been reviewed and revised. The MCO stated, "I don't know, we are unable to provide additional information to resolve the concern."</p> <p>2. Resident #4 was admitted to the facility on 10/25/13 and re-admitted on 3/28/14 with multiple diagnoses to include aftercare for fall with fracture, recent CVA, left-sided hemiplegia and expressive aphasia.</p> <p>Resident #4's most recent Quarterly MDS assessment, dated 4/7/14, coded the following:</p> <ul style="list-style-type: none"> <li>- Extensive assistance of two people for bed mobility, transfers, dressing, and toileting.</li> <li>- Walking in her room, locomotion on and off the unit did not occur.</li> <li>- Upper and Lower extremity impairment (limitation).</li> </ul> <p>The resident's Self-Care Deficit CP, dated 12/6/13, included a handwritten entry on 4/1/14, "toe touch weight bearing." The CP failed to identify which leg was to be toe touch weight bearing.</p> <p>The resident was observed on 5/5/14 at 2:25 PM applying full weight to both lower extremities during a transfer with a physical therapist. Approximately five minutes later the resident was observed in the therapy room walking between the parallel bars, bearing full weight to both lower extremities.</p> <p>On 5/9/14 at 9:20 AM, the MCO, DNS, and SDC were interviewed. The MCO stated the resident</p>	F 280	<p>4. Ongoing Audits</p> <p>Beginning the week of 6/25/14, 3 resident care plans will be audited by the Director of Nursing or designee to ensure that they reflect the care and services provided weekly X4 weeks and then monthly X2 months. The results of these audits will be reported to the Performance Improvement Committee for review monthly X3 months or until resolved with remedial measures implemented as needed. The Director of Nursing is responsible for monitoring and follow-up.</p>	6/25/14
-------	---	-------	--	---------

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/09/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>		
(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 280	<p>Continued From page 9</p> <p>had an order for toe touch weight bearing when she was readmitted to the facility after her hip fracture, but she was now full weight bearing to her left lower extremity. The surveyor asked the MCO when it was determined the resident could return to full weight bearing and why the toe touch weight bearing was still on the CP. The MCO stated she did not know and was unable to provide additional information to resolve the concern.</p> <p>3. Resident #5 was admitted to the facility on 12/21/09 and readmitted on 1/26/11 with multiple diagnoses which included peripheral vascular disease and depression.</p> <p>The resident's Restorative Nursing CP, dated 4/16/14, documented the following goals: -The resident would "demonstrate functional ROM by performing exercises daily," with a target date of 7/16/14; and, -"Perform AM/PM warm up exercises with assistance," with a target date of 7/16/14.</p> <p>Record review revealed the resident was not on a restorative nursing plan or program.</p> <p>On 5/9/14 at 3:00 PM, the MDS Coordinator was interviewed regarding the restorative nursing plan. She stated the resident "is not on a restorative plan or program."</p> <p>On 5/9/14 at 3:15 PM, when the NPE was shown the Restorative Nursing CP, she stated, "I would say the care plan does not fit and the care plan should be revised."</p>	F 280		

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/09/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>		
(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 280	Continued From page 10	F 280			
F 309 SS=D	<p>On 5/8/14 at 4:50 PM, the Administrator and MCO were made aware of the care plan concerns; no additional information was provided by the facility.</p> <p><b>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b></p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure residents received the necessary care and services to attain or maintain their highest practicable well-being. This was true for 2 of 11 (#6 &amp; #11) sampled residents. The facility failed to follow the physician order for suprapubic catheter care for Resident #6 and failed to follow the physician's medication dosing orders for Resident #11. This had the potential to place residents at risk for not receiving the appropriate care and/or services. Findings included:</p> <p>1. Resident #6 was admitted to the facility on 2/15/13 and readmitted on 11/22/13 with diagnoses that included rehabilitation and pneumonia.</p> <p>The All Active Orders (Recapitulation) for May</p>	F 309	<p>F309</p> <p>Residents affected</p> <p>Resident #6 was assessed by the licensed nurse on 6/10/14 for any adverse effects related to lack of catheter care documentation with none noted. Suprapubic catheter care was provided by the MDS nurse on 6/10/14. The physician was notified of the occurrence on 6/10/14 by Director of Nursing with no new orders noted.</p> <p>Resident # 11 discharged from Payette Center on 5/14/14.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/09/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>		
(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 309	<p>Continued From page 11</p> <p>2014 documented, "Suprapubic [Suprapubic] catheter care every shift; cleanse stoma site and cover with gauze dressing - Night Shift, Day Shift Everyday."</p> <p>The Care Plan for suprapubic catheter related to urinary retention, BPH, (benign prostate hypertrophy), kidney and ureter disorder, initiated on 11/22/2013, documented an intervention, "Catheter care q [every] shift and PRN" with an initiated date of 11/22/13 and revised on 12/4/13.</p> <p>The TAR for April 2014, documented the resident did not receive catheter care for any shift from 4/1 - 4/17/14. The first catheter care documented occurred on 4/18/14 on the day shift, however, the night shift did not document the resident received catheter care. Additionally, no documentation was found for the rest of the month of April for the following shifts: *Day Shift - 4/20-22, 4/27-29. *Night Shift - 4/24-25, 4/30.</p> <p>On 5/8/14 at 2:30 PM, the NPE was interviewed regarding not following the physician order for suprapubic catheter care for Resident #6. The NPE stated, "I don't see that catheter care is documented as ordered."</p> <p>On 5/8/14 at 4:50 PM, the Administrator and MCO were informed of the concern with following physician orders. No further information was provided by the facility.</p> <p>2. Random Resident #11 was admitted to the facility with multiple diagnoses to include CHF, Coronary Artery graft, obstructive sleep apnea, and MRSA.</p> <p>On 5/7/14 at 8:40 AM, the resident was observed</p>	F 309	<p>2. Other residents with the potential to be affected.</p> <p>A review of residents who have indwelling urinary catheters was completed by Nurse Practice Educator on 6/13/14 to ensure that catheter care was documented as completed as ordered. No additional concerns noted.</p> <p>A review of residents active physicians orders as compared to the MAR will be completed by the Director of Nursing or designee on or before 6/25/14 to ensure that medications are transcribed/ administered as ordered. MD notification and follow up was completed as needed.</p> <p>3. Systemic change</p> <p>Licensed nursing staff will be re-educated by the Nurse Practice Educator on or before 6/25/14 on the medication and treatment administration policy including that</p>	

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>05/09/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>		
(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 309	Continued From page 12 sitting in her room eating her breakfast. RN #3 asked the resident if she was ready for her morning medication. At 8:45 AM, RN #3 administered the following 2 medications to RR #11: - CellCept (immunosuppressive) 500 mg, take 1 tablet by mouth three times every day. Take two hours apart from omeprazole and protonix. - Omeprazole 40 mg capsule DR, take 1 capsule by mouth every day.  On 5/7/14 at approximately 10:00 AM, reconciliation of the aforementioned medications with the resident's recapitulation of Active Orders for May 2014 revealed the Cellcept was to be given two hours apart from the Omeprazole and the Omeprazole was to be given prior to the meal.  On 5/7/14 at approximately 10:05 AM, RN #3 was asked when the Omeprazole should be given per manufacturer's specifications. RN #3 stated the omeprazole should be given one hour before the meal. RN #3 was then asked to review the order for the CellCept. RN #3 stated it should not be given with the Omeprazole, it should have been given two hours apart from the Omeprazole. RN #3 stated the night shift nurse had processed the order on 5/6/14 and added it to the MAR, but did not include the information related to administration.  On 5/7/14 at 10:30 AM, the MCO and DNS were informed of the issue. No other information was received from the facility which resolved the issue.	F 309	treatments are signed off in the TAR after administration and that medication orders are transcribed and administered as ordered.  4. Ongoing Audits  Beginning the week of 6/25/14 an audit of 3 residents records will be completed by the Director of Nursing or designee to ensure that medications and treatments are transcribed and administered per MD order weekly X4 weeks and then monthly X2 months. These audits will be reported to the Performance Improvement Committee for review monthly X3 months or until resolved with remedial measures implemented as needed. The Director of Nursing is responsible for monitoring and follow up.	6/25/14	
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314			

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>05/09/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>		
(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 314	Continued From page 13  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.  This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, it was determined the facility failed to ensure residents who entered the facility without pressure ulcers did not develop unstageable pressure ulcers. Additionally, the facility failed to provide the necessary nursing care and services to promote healing of pressure ulcers. This was true for 1 of 9 (#3) sampled residents reviewed for pressure ulcers. This deficient practice caused harm when the facility failed to recognize and assess Resident #3's wounds as pressure ulcers and failed to treat and promote wound healing. Findings included:  Resident #3 was admitted to the facility on 7/21/08 and readmitted on 3/11/14 with multiple diagnoses including rehabilitation, aftercare healing of pathologic fracture of the left lower leg, muscular wasting and disuse atrophy, abnormality of gait and unspecified osteoporosis.  An Incident/Accident Report (I&A), initiated at the facility on 3/7/14 at 12:00 PM, documented the resident fell, fractured her left ankle and was transferred to a local hospital. An	F 314	F314  Residents affected  Resident #3 discharged from Payette Center on 5/23/14.  2. Other residents with the potential to be affected.  Members of nurse management updated residents' Braden scores and reviewed current wounds for healing to assess for risk for skin breakdown and delayed healing on or before 6/17/14. Resident care plans were updated according per IDT recommendations by the Nurse Practice Educator on or before 6/20/14. Licensed nurses completed skin assessments for current residents on 6/20/14 with no new pressure areas identified.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 05/09/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  PAYETTE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1019 THIRD AVENUE SOUTH PAYETTE, ID 83661
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 314	<p>Continued From page 14</p> <p>Operative/Procedure Report by a local orthopaedic surgeon, dated 3/8/14, documented the resident required surgical intervention.</p> <p>The resident's 14 day admission MDS assessment, dated 3/23/14, coded: *Moderately impaired decision making skills. *No rejection of cares. *Dependent on 2+ persons for bed mobility, transfers, dressing and toilet use. *At risk for developing pressure ulcers. *No pressure ulcers present on admission.</p> <p>The Recapitulation Orders, dated 3/12/14, documented the following: *Wound dressing site to be observed every shift every day; *Float heels with pillows while in bed every shift every day; *Pressure reducing mattress to bed; *Pressure redistribution cushion to chair; *Trapeze over bed for bed mobility; and, *Weekly skin assessments by LN on Tuesday.</p> <p>The March 2014 TAR (Treatment Administration Record) did not document Resident #3's heels were floated on: *Day Shift - 3/12, 3/19 and 3/20. *Evening Shift - 3/25. *Night Shift - 3/12, 3/14-15, 3/20-22, 3/27-29.</p> <p>The March 2014 TAR did not document Resident #3's wound dressing site was observed every shift: *Day Shift - 3/12, 3/19, and 3/20. *Evening Shift - 3/25. *Night Shift - 3/12, 3/14-15, 3/20-22, and 3/27-29.</p> <p>The resident's care plan for skin integrity related</p>	F 314	<p>Additionally a skin round was completed by the nurse management team on 6/20/14 to ensure that interventions were implemented per the plan of care.</p> <p>Residents with wounds treatment orders were review by the Director of Nursing or 6/20/14 to ensure that treatment was received and administered timely upon the receipt of the order. No new concerns noted. Residents with skin impairment were reviewed by the dietician on 6/18/14 to ensure that nutritional needs for healing were being met.</p> <p>3. Systemic Change</p> <p>Staff were re-educated on or before 6/25/14 by the Nurse Practice educator or designee on wound assessment, and to ensure that pressure reducing mattresses are in place as ordered and to ensure that resident that are admitted with wounds have a skin integrity report initiated including measurements with weekly follow-up</p>	
-------	---	-------	---	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/09/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>		
(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 314	<p>Continued From page 15</p> <p>to surgical wound, initiated on 3/13/14, documented:</p> <ul style="list-style-type: none"> <li>*"(CMS (color, motion, sensation) checks to LLE (left lower extremity).</li> <li>*Elevate legs as much as possible and as resident will allow.</li> <li>*Observe wounds under Podus boot every shift and PRN.</li> <li>*Report worsening of s/sx (signs and symptoms) of infection to MD.</li> <li>*Vascular studies/consults per MD orders.</li> <li>*Wound care per MD orders.</li> <li>*Wound check every other day."</li> </ul> <p>A progress note, dated 3/19/14, documented the resident was first seen post operatively by the orthopaedic surgeon for a follow up visit of the left ankle. The progress note documented the resident was having "significant pain"...and had "been in a splint non-weight bearing." The splint was removed and there were "some resolving fracture blisters on both sides of the ankle." The resident was started on an antibiotic with the plan to "ice and elevate her ankle as much as possible. Continue non-weight bearing in the splint." The resident was to be seen in one week for follow up.</p> <p>A progress note, dated 3/26/14, the resident was seen by the orthopaedic surgeon for a two week follow up visit of her left ankle. The progress note documented the "incisions looked good" but the resident appeared to have a heel ulcer with "some black, necrotic tissue." The plan included transitioning the resident into a heel off-loader brace. The resident was given a new splint in the physician's office "with a significant amount of heel padding" until a heel off-loader brace could be set up. The resident was to be seen in one</p>	F 314	<p>until wound is resolved with MD notification and updated if delay in healing is identified, per policy, and ensuring that orders and care plan interventions are followed and associated documentation is completed per policy, and that dietician reviews residents with skin impairment to ensure that nutritional needs for healing are being met.</p> <p>4. Ongoing Audits</p> <p>Beginning the week of 6/25/14, 3 residents will be assessed by the Director of Nursing or designee to ensure that pressure ulcer prevention measures are in place including pressure support surfaces and devices and that physicians orders and interventions including nutritional interventions are followed per the plan of care for any existing wounds. These audits will be completed weekly X4 weeks and then monthly X2 months. The results of these audits will be reported to the Performance Improvement Committee for review</p>	

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>05/09/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>
---	---

(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 314	<p>Continued From page 16 week for follow up.</p> <p>The Recapitulation Orders documented an order, dated 3/26/14, to ensure an off loading Podus boot was in place every shift, everyday.</p> <p>A care review progress note, dated 3/27/14, documented the resident went yesterday and the physician "noted a pressure ulcer on the left heel. Physician did not write anything about it but van driver stated physician saw it." The note documented the "Wd [wound] nurse will evaluate and ask for orders. Res[ident] is getting up 3 X [times] a day and encouraged to stay up for as long as possible."</p> <p>The April 2014 MAR did not document that the off loading Podus boot was in place every shift as ordered for the following: *Evening Shift - 4/28. *Night Shift - 4/3-5, 4/10-12, 4/17-18, 4/24-25 &amp; 4/30.</p> <p>Additionally, the April 2014 MAR did not document the resident's heels were floated on: *Evening Shift - 4/28. *Night Shift - 4/3-5, 4/10-12, 4/17-18, 4/24-25 &amp; 4/30.</p> <p>The April 2014 MAR also documented the wound dressing site was not observed every shift for the following: *Day Shift - 4/10, &amp; 4/12. *Evening Shift - 4/28. Night shift - 4/3-5, 4/10-12, 4/17-18, 4/24-25 &amp; 4/30.</p> <p>A physician progress note, dated 4/4/14, documented the resident was seen for a four week follow up visit by the orthopaedic surgeon.</p>	F 314	<p>monthly or until resolved with remedial measures implemented as needed. The Director of Nursing is responsible for monitoring and follow-up.</p>	6/25/14
-------	---	-------	---	---------

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/09/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>		
(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 314	<p>Continued From page 17</p> <p>The progress note documented the "heel wound had not worsened. She has developed a blood filled blister on the ball of her foot, as well as on the lateral aspect of her foot."</p> <p>A care review progress note by the NPE, dated 4/4/14, documented the resident had a "DTI (deep tissue injury) to the left heel R/T (related to the splint" and was "dark purple in color" but not open. In addition, it was documented the "Res[ident] states she would like to lose weight."</p> <p>NOTE: The resident's need for added nutrition for healing related to an ankle fracture and pressure ulcers was not addressed.</p> <p>A physician progress note, dated 4/4/14, documented the resident was examined by the orthopaedic surgeon and was five weeks out from her surgery. The progress note documented the resident was "complaining of achiness and pain in her left foot and ankle." The physical examination documented:          *Black eschar (dead tissue) at the heel.          *Black eschar at the plantar surface (sole) of the first MTP (big toe) joint.          *Black eschar along the lateral aspect (outer side) of the foot.          *Erythema (redness) at the top of the foot with a small dime-sized area of eschar over the first metatarsal.          The plan documented to "Continue with daily wound care. I have started her on some Keflex 500 mg four times a day for seven days."</p> <p>On 4/14/14, a progress note documented, "air mattress placed today."</p> <p>NOTE: The pressure reducing mattress was</p>	F 314		

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/09/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>
---	---

(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 314	<p>Continued From page 18</p> <p>ordered on 3/12/14, and was placed on the resident's bed a month after the facility received the physician's order.</p> <p>On 4/16/14, the resident was examined by the orthopaedic surgeon who documented: *Left ankle wounds draining; *Heel ulcer with eschar; *Lateral foot necrosis; * 4, 5 toes necrosis; and, *Dorsal (top) foot wound. The surgeon documented, "A/P (Assessment/Plan) Prognosis not looking good for foot. Will need arterial vascular studies and vasc [vascular] surgeon consult."</p> <p>On 4/17/14, the resident was examined by her family practice physician, for wound check and one month follow up. The physician documented, "L [left] foot was in cast after surgery, then had splint placed, was wrong kind, did not off-load. Unclear if this led to current problem. Now has correct boot on. Had developed some dark spots on foot, oozing, incision not healed. Called by staff 2 days ago, I asked her to come in to evaluate." The skin exam documented, "multiple dark patches on L foot, lateral is dripping some dark blood. No bad odor. Global erythema, dusky, and non-blanching, quite tender in some spots, not in others." The Provider Plan documented, "Appears to be areas of necrotic and non-viable tissue of foot...Agree with vascular study."</p> <p>An Ultrasound Report, dated 4/18/14, documented, "...left ankle-brachial index is within normal limits."</p> <p>The Recapitulation Orders, dated 4/21/14, documented the following orders:</p>	F 314		
-------	---	-------	--	--

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/09/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>
---	---

(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 314	<p>Continued From page 19</p> <p>*Check CMS to left lower extremity/foot/toes every shift - Every shift Everyday Assessment. *Remove Podus boot to left foot/ankle every shift for a skin check under boot. Ensure boot is replaced and left heel is fully suspended - Every Shift Everyday Assessment.</p> <p>The April 2014 MAR did not document CMS checks or removal of the Podus boot for the following: *Evening Shift: 4/28. *Night Shift: 4/24-25 &amp; 4/30.</p> <p>The Vascular Report, dated 4/22/14, documented "there appears to be adequate perfusion to heal..."</p> <p>A progress note by the NPE, dated 4/22/14, documented a video conference with the NPE and head of the facility's ownership Skin Integrity Program. The head of the facility's Skin Integrity Program recommended a change of treatment to the lateral ankle wound. The NPE called and obtained an order from the orthopaedic surgeon's PA (physician's assistant) for the following: *Surgical incision wound care: Cleanse lateral incision area with 1/4% Dakins solution and cover with optifoam silver (Ag) and rolled gauze BID (twice daily). If medial wound is draining, may use same treatment as lateral wound. If not draining or no s/sx of infection, may lightly cover with telfa of border gauze BID - Every 12 hours Everyday. Scheduled at 8 AM and 8 PM.</p> <p>The April 2014 MAR did not document the treatment to the lateral ankle wound as ordered on 4/22/14 for the following: *4/28 at 8 PM.</p>	F 314		
-------	---	-------	--	--

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/09/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH</b> <b>PAYETTE, ID 83661</b>		
(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 314	<p>Continued From page 20</p> <p>The Recapitulation Orders, documented the following order, dated 4/23/14: *Chlorhexidine to black necrotic areas daily - Day Shift Everyday.</p> <p>The April 2014 MAR did not document Chlorhexidine was applied to black necrotic areas daily for the following dates: *4/24-27.</p> <p>NOTE: This order had a start date of 4/23/14 but was not started until 4/28/14.</p> <p>On 4/28/14 the resident was seen by the vascular surgeon who documented in his report, "The patient's foot certainly does not look good and she is a [at] risk to lose it. I do feel, however, that her blood supply is playing a significant role in this and based on an ultrasound examination and the clinical examination of her foot, I do not believe that revascularization given that she has mild vascular disease is likely to improve her healing. Therefore, I am recommending continued wound care. Clearly there is still a significant issue in the patient's healing, perhaps nutritional, perhaps infection, perhaps related to inadequate offloading. I encourage you to address all of these...her blood supply is not playing a significant role."</p> <p>The May 2014 MAR did not document the resident's heels were floated on: *Evening Shift - 5/6. *Night Shift - 5/2-3.</p> <p>The May 2014 MAR did not document the resident's Podus boot was in place during the following times:</p>	F 314		

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>05/09/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>		
(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 314	<p>Continued From page 21</p> <p>*Evening Shift - 5/6. *Night Shift - 5/2-3.</p> <p>The May 2014 MAR did not document the resident's wound dressing site were observed during the following times: *Evening Shift - 5/6. *Night Shift - 5/2-3.</p> <p>The May 2014 MAR did not document the resident's Podus boot to the left foot/ankle was removed and skin check performed under the boot, or that the boot was replaced and the left heel fully suspended during the following times: *Evening Shift - 5/6. *Night Shift - 5/2-3.</p> <p>The May 2014 MAR did not document CMS checks to the resident's lower extremity/foot/toes were completed during the following times: *Day Shift: 5/3, *Evening Shift: 5/6. *Night Shift: 5/2-3.</p> <p>The May 2014 MAR did not document the resident's surgical incision wound received care every 12 hours during the following times: *5/3 - 8:00 AM. *5/6 - 8:00 PM.</p> <p>The Skin Integrity Report sheets documented the type of wound as vascular for all seven wounds and contained spaces to document at the date of each assessment - Pain, Appearance, Length (cm), Width (cm), Surrounding Tissue, Wound Edges and Care Plan Updated. a. Anatomical Location: Left heel 3/26/14 - painful, 100% black adherent eschar, 4.4 cm L (length) x 5.4 cm</p>	F 314		

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 05/09/2014
NAME OF PROVIDER OR SUPPLIER  PAYETTE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 THIRD AVENUE SOUTH PAYETTE, ID 83661		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	Continued From page 22 W (width), inflamed, dry, care plan updated. 4/4/14 - painful, 100% black adherent eschar, 4.2 cm L x 5.4 cm W, inflamed, dry. 4/11/14 - painful, 100% black adherent eschar, 4 cm L x 5.4 cm W, inflamed, dry. 4/14/14 - painful, 100% black adherent eschar, 4 cm L x 5.2 cm W, inflamed/red, dry. 4/22/14 - painful, 100% black adherent eschar, 4 cm L x 5.2 cm W, red, dry. 4/29/14 - painful, 100% black adherent eschar, 3.9 cm L x 5.2 cm W, red, dry. 5/6/14 - no pain, 100% black adherent eschar, 3 cm L x 6 cm W, healthy, healthy. NOTE: Wound edge choices were "healthy, calloused, macerated, rolled," but not "dry" as documented.  b. Anatomical Location: Left dorsal foot 4/4/14 - no pain, 100% pink epithelial, 1 cm L x 1.2 cm W, scant serous, healthy, healthy. 4/5/14 - no pain, 100% black eschar, 1 cm L x 1.2 cm W, healthy, healthy, care plan updated. 4/11/14 - no pain, 100% black adherent eschar, 1 cm L x 1.2 cm W, healthy, healthy. 4/22/14 - no pain, 100% black adherent eschar, 1 cm L x 1.3 cm W, healthy, healthy. 4/29/14 - no pain, 100% black adherent eschar, 1 cm L x 1.2 cm W,	F 314			

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>05/09/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>
---	---

(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 314	<p>Continued From page 23</p> <p>healthy, healthy.</p> <p>5/6/14 - no pain, 100% yellow eschar, 1 cm L x 1.2 cm W, healthy, healthy.</p> <p>c. Anatomical Location: Left lateral foot</p> <p>4/4/14 - painful, 100% blood blister, 6.8 cm L x 3 cm W, inflamed, inflamed, care plan updated.</p> <p>4/11/14 - painful, 100% black adherent eschar, 7 cm L x 3 cm W, inflamed, inflamed.</p> <p>4/14/14 - painful, 100% black adherent eschar, 7 cm L x 3 cm W, pale, pale.</p> <p>4/22/14 - painful, 100% black adherent eschar, 6.3 cm L x 4.5 cm W, pale, pale.</p> <p>4/29/14 - painful, 100% black adherent eschar, 6.5 cm L x 4.5 cm W, pale, pale.</p> <p>5/6/14 - painful, 100% black adherent eschar, 7 cm L x 6 cm W, healthy/pale, healthy/pale.</p> <p>NOTE: Wound edge choices were "healthy, calloused, macerated, rolled," but not "inflamed" or "pale" as documented.</p> <p>d. Anatomical Location: Left medial ball of foot</p> <p>4/4/14 - painful, 100% blood blister, 2 cm L x 2.5 cm W, inflamed, red, care plan updated.</p> <p>4/11/14 - painful, 100% black eschar, 1.6 cm L x 2.1 cm W, healthy, red.</p> <p>4/14/14 - painful, 100% black adherent eschar, 1.6 cm L x 2.1 cm W,</p>	F 314		
-------	---	-------	--	--

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 05/09/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  PAYETTE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1019 THIRD AVENUE SOUTH PAYETTE, ID 83661
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 314	<p>Continued From page 24</p> <p>healthy, red. 4/22/14 - painful, 100% black adherent eschar, 1.6 cm L x 2.1 cm W, healthy, red. 4/29/14 - painful, 100% black adherent eschar, 1.5 cm L x 2.1 cm W, healthy, red. 5/6/14 - not painful, 100% black adherent eschar, 1.5 cm L x 1.5 cm W, healthy, healthy.</p> <p>NOTE: Wound edge choices were "healthy, calloused, macerated, rolled," but not "red" as documented.</p> <p>e. Anatomical Location: Left 4th toe, top 4/4/14 - painful, intact purple, 2 cm L x 0.5 cm W, inflamed, healthy. 4/11/14 - painful, intact purple, 1.8 cm L x 0.5 cm W, inflamed, healthy. 4/14/14 - painful, intact purple, 1.8 cm L x 0.5 cm W, inflamed, healthy. 4/29/14 - painful, intact purple, 1.9 cm L x 0.5 cm W, inflamed, healthy. 5/6/14 - painful, intact purple, 1.9 cm L x 0.5 cm W, healthy/pale, healthy.</p> <p>f. Anatomical Location: Left lateral ankle/surgical incision/cellulitis 4/4/14 - painful, 75% dark scab 25% slough, 8 cm L x 1.8 cm W, moderate serosanguineous, inflamed, red, care plan updated. 4/11/14 - painful, 50% epithelial (ex:stg 2) 50% slough, 8 cm L x 2.3 cm W, minimum serosanguineous, inflamed, red. 4/14/14 - painful 75% epithelial (ex:stg 2) 25%</p>	F 314		
-------	---	-------	--	--

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/09/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH</b> <b>PAYETTE, ID 83661</b>		
(X4) ID PREFIX TAG  <b>F 314</b>	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG  <b>F 314</b>	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Continued From page 25</p> <p>slough, 7.8 cm L x 2.5 cm W, moderate serosanguineous, inflamed, red. 4/22/14 - painful, 75% epithelial (ex:stg 2) 25% slough, 8.8 cm L x 1.4 cm W, moderate heavy serosanguineous, inflamed, red. 4/29/14 - painful, 75% epithelial (ex:stg 2) 25% slough, 8.2 cm x 1.7 cm W, moderate serosanguineous, inflamed, red. 5/6/14 - painful, 25% yellow eschar 25% black eschar, 50% epithelial (ex:stage 2), 7 cm L x 2.6 cm W, moderate serosanguineous, inflamed, fragile.</p> <p>NOTE: Wound edge choices were "healthy, calloused, macerated, rolled" but not "red" as documented.</p> <p>g. Anatomical Location: Left medial ankle/surgical incision 4/4/14 - painful, 50% dark scab 50% slough, 6 cm L x 0.5 cm W, minimal serosanguineous, inflamed, red, care plan updated. 4/11/14 - painful, 50% epithelial (ex:stg 2) 50% slough, 5 cm L x 0.5 cm W, healthy, healthy. 4/14/14 - painful, 75% epithelial (ex:stg 2) 25% slough, 5 cm L x 0.5 cm W, healthy, healthy. 4/22/14 - not painful, &gt; 75% epithelial (ex:stg 2) &lt; 25% slough, 5 cm L x 0.5 cm W, healthy, healthy. 4/29/14 - not painful, &gt; 75% epithelial (ex:stg 2) &lt; 25% slough, 5 cm L x 0.5 cm W, healthy, healthy.</p>			

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/09/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>		
(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 314	<p>Continued From page 26</p> <p>5/6/14 - not painful, 75% granulation 25% slough, 1.5 cm L x 0.5 cm W x 0.1 cm depth, healthy, healthy.</p> <p>On 5/7/14 at 3:55 PM, the surveyor observed the wounds to the resident's left foot with the NPE. The NPE stated she first became involved with the resident's care on 4/4/14. The NPE took the following measurements:            *left heel - 3.6 cm L x 6.5 cm W - eschar present.            *left dorsal - 1.4 cm L x 1 cm W - eschar present.            *left lateral foot - 8 cm L x 6 cm W - eschar present.            *left medial ball of foot - 1.3 cm L x 1.5 cm W - eschar present.            *left 4th toe - 2.1 cm L x 0.7 cm W, eschar present.            *left lateral ankle incision site had healed, approximately 1" below the incision site an open area measured 8 cm L x 2.4 cm W.            *left medial incision - 1.9 cm L x 0.4 cm W with inflamed wound edges</p> <p>On 5/9/14 at 10:20 AM, the NPE and the MCO were interviewed regarding the resident's left foot wounds. The surveyor questioned the NPE regarding the missing data in documentation on the March, April and May 2014 TARs in which heels were not consistently floated, wound dressing site not observed every shift, CMS not performed, Podus boot not removed, Podus boot not offloaded or replaced and the left heel not fully suspended. The NPE confirmed that information was missing in the MARs and stated the "holes" were a "problem." When asked about the 4/23/14 order for Chlorhexidine to black necrotic areas daily and why there was no documentation on the April 2014 MAR for 4/26</p>	F 314		

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>05/09/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>		
(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 314	<p>Continued From page 27</p> <p>and 4/27, the NPE stated the facility didn't have Chlorhexidine available, that it had been ordered on 4/24/14 but was not started until 4/28/14. She stated there was "some confusion" with the pharmacy related to preparation. When asked why the facility waited 4 days in letting the pharmacy know staff did not have the Chlorhexidine, the NPE did not have an answer.</p> <p>She then stated she was responsible for the missing 4/28/14 documentation on the evening shift but could not explain the cause for the other missing documentation. She stated it looked like there was a "pattern." When asked about the documentation on 4/17/14 in which the physician stated the resident received the "wrong" boot, the NPE and MCO both stated there was not a significant difference between the two types of boot. Both the NPE and MCO stated the orthopaedic surgeon's office ordered the boot and it was fitted by the company representative. They both stated the resident would have the same skin issues even if she had been fitted with the correct boot. The MCO stated the boot did not contribute to the ulcers originally documented as "pressure" but been changed to "vascular" after consulting with the orthopaedic surgeon.</p> <p>When asked about the vascular report which documented, "there appears to be adequate perfusion to heal" (wounds), the NPE stated, "there was a lot of gray area in the report and wasn't sure exactly what that pertained to." When asked about the vascular surgeon's report in which he documented the resident's left foot "did not look good" and she was at risk to lose it, the NPE stated she agreed with the physician.</p> <p>On 5/9/14 at 11:30 AM, the NPE stated she</p>	F 314		

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 05/09/2014
NAME OF PROVIDER OR SUPPLIER  PAYETTE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 THIRD AVENUE SOUTH PAYETTE, ID 83661		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	Continued From page 28 consulted with the corporate wound care specialist who gave the recommendation for a new treatment order. It was after this change of treatment on 4/22/14 that the wounds started to improve.  The facility consistently failed to: *Adequately assess the left foot wounds as pressure ulcers instead of vascular ulcers. The pressure ulcer to the heel was first noticed on 3/26/14, however, a wound specialist was not consulted until 4/22/14; *Float the resident's heels; *Observe the wound dressing site; *Offload the Podus boot every shift; *Check the CMS of the left lower extremity every shift; *Remove the Podus boot every shift for a skin check under the boot, replace the boot and ensure the left heel was fully suspended every shift; *Order an air mattress in a timely matter; *Follow up with the pharmacy for the order of Chlorhexidine and the resident had to wait 4 days for the medication.	F 314			
F 323 SS=G	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	F 323			

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/09/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>	
(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 323	<p>Continued From page 29</p> <p>by: Based on medical record review, policy review, and staff and resident interview it was determined the facility failed to ensure residents received adequate supervision and staff assistance to prevent falls with injuries. This was true for 2 of 3 (#s 3 &amp; 4) residents sampled for falls. Resident #3 was harmed when she fell and suffered a left ankle fracture and Resident #4 was harmed when she fell and suffered a left hip fracture. Additionally, the facility failed to ensure siderails were assessed as safe for 3 of 5 (#s 1, 3, &amp; 4) residents sampled for siderails use. Findings included:</p> <p>The facility's Policy and Procedure for, "Falls Management," documented the following: - "Patients will be assessed for falls risk as part of the nursing assessment process. Those determined to be at risk will receive appropriate interventions to reduce risk and minimize injury." - Purpose of the policy is "to reduce the risk for falls and minimize the actual occurrence of falls and to address injury and provide care for a fall." - Patients with a score of 12 and above on the Fall Risk Evaluation are "at risk" of falls. - Develop individualized plan of care. - Review and revise care plan regularly.</p> <p>1. Resident #4 was admitted to the facility on 10/25/13 and re-admitted on 3/28/14 with multiple diagnoses to include aftercare for fall with fracture, recent CVA, left-sided hemiplegia and expressive aphasia.</p> <p>Resident #4's Quarterly MDS assessment, dated 1/14/14, coded the following: - Extensive assistance of one person for bed mobility, transfers, dressing, toileting, and</p>	F 323	<p>F323 Residents affected</p> <p>Resident #3 discharged from Payette Center on 5/23/14.</p> <p>Resident #4 was assessed by the MDS nurse on or before 6/17/14, and the resident's plan of care was updated to include fall interventions that reflect the level of supervision needed.</p> <p>Resident #4 side rails were evaluated for safety by licensed nurse on 6/17/14.</p> <p>Resident #4 was assessed for adverse effect related to side rail use by the licensed nurse on 6/18/14.</p> <p>Resident #1's side rails were evaluated for safety by licensed nurse on 6/17/14 and the resident was found to be safe.</p> <p>Resident #1 was assessed for adverse effect related to side rail use by the licensed nurse on 6/18/14 and the resident was found to be safe.</p> <p>2. Other residents with the potential to be affected</p>

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 05/09/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  PAYETTE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1019 THIRD AVENUE SOUTH PAYETTE, ID 83661
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 323	<p>Continued From page 30</p> <p>personal hygiene.</p> <ul style="list-style-type: none"> <li>- Limited assistance of one person to walk in room and for locomotion on and off the unit.</li> <li>- Upper and Lower extremity impairment (limitation).</li> </ul> <p>Resident #4's most recent Quarterly MDS assessment, dated 4/7/14, coded the following:</p> <ul style="list-style-type: none"> <li>- Extensive assistance of two people for bed mobility, transfers, dressing, and toileting.</li> <li>- Walking in her room, locomotion on and off the unit did not occur.</li> <li>- Upper and Lower extremity impairment (limitation).</li> </ul> <p>Resident #4's Care Plan, Incident/Accident Reports, Physical Therapy Notes, Occupational Therapy Notes, Nursing Notes, hospital History &amp; Physical, facility faxes, and x-ray results were reviewed and documented the following:</p> <ul style="list-style-type: none"> <li>* Fall Risk Evaluation, dated 10/25/13, documented a score of 12 or above indicated the resident was at high risk for falls; the resident scored a "16."</li> <li>* The resident's Fall Care Plan (CP), initiated on 10/27/13, documented, "pressure alarm when in bed and tab alarm when up in w/c; mats on floor next to both sides of bed; assist resident getting in and out of bed with 2 person assistance; have commonly used articles within easy reach; resident to wear non-slip footwear" with the hand written words, "for assisted transfers."</li> <li>* An Incident/Accident Report (I&amp;A), initiated on 10/30/13 at 4:45 PM, and completed on 5/12/14, documented:             <ul style="list-style-type: none"> <li>- "Resident is alert, poor safety awareness, with</li> </ul> </li> </ul>	F 323	<p>Residents fall risk was reassessed by the nurse management team on or before 6/10/14. Residents identified to be at high risk for falls were reviewed by the Director of Nursing or designee on or before 6/25/14 to ensure that care plan in place with interventions that are based on the residents' current status including level of supervision required.</p> <p>Residents were reviewed by the Director of Nursing or designee on or before 6/25/14 to ensure that side rails are necessary and have been evaluated for safe use by residents and that they are non-restrictive.</p> <p>3. Systemic Change</p> <p>Center staff were re-educated on or before 6/25/14 by the Nurse practice Educator or designee on facility fall prevention policy and the need to ensure that the care plan is in place and revised and based on the current care need, and orders and that the level of supervision is reflected in the plan of care, and on residents who require side rails that they are evaluated and assessed for safety per policy and that their use is reflected in the plan of care.</p>	
-------	--	-------	---	--

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/09/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>		
(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 323	<p>Continued From page 31</p> <p>left sided weakness. She was in her room going through the night stand drawers. A CNA had been in the room just prior to fall and had moved some items so the resident could search drawers without reaching. CNA left the room and a few moments later, the residents alarm was sounding. She was on the floor facing the door with her buttocks pushed against drawer.</p> <ul style="list-style-type: none"> <li>- Care Plan updated - No.</li> <li>- Newly admitted s/p CVA with left sided deficit.</li> <li>- Interventions initiated after the fall - Assessed resident for new onset pain or injury, assisted resident up from the floor with 2 person extensive assist and assisted to bed. Alarm re-applied to resident and placed on increased staff supervision.</li> <li>- Recommendations to prevent further falls - continue with alarm on at all times. Increase staff supervision.</li> <li>- Root Cause Inclusion - Resident's poor safety awareness and generalized weakness secondary to CVA with left sided deficit.</li> <li>- Summary of staff interview - CNA had just left the resident's room after placing items within reach of resident."</li> </ul> <p>* The Fall CP, initiated on 10/30/13, documented, "increased staff supervision."</p> <p>NOTE: The facility documented increased supervision was implemented per the I&amp;A and the Fall Care plan on 10/30/13; however, the facility failed to identify what increased supervision was to include, for example what specific times the resident would be observed.</p> <p>* An I&amp;A Report, initiated on 11/6/13 at 3:15 PM, and completed on 5/12/14, documented: - "Resident found by CNA sitting on floor in front</p>	F 323	<p>4. Ongoing Audits</p> <p>Beginning the week of 6/25/14 an audit of 3 residents will be completed by the Director of Nursing or designee to ensure that resident identified at risk for falls have a care plan in place with interventions and revisions to the plan of care and that needed increased supervision is reflected in the plan of care, and that residents who require side rails are assessed for safety weekly X4 weeks and then monthly X2 months. The results of these audits will be reported to the Performance Improvement Committee for review monthly for 3 months or until resolved with remedial measures implemented as needed. The Director of Nursing is responsible for monitoring and follow-up.</p> <p style="text-align: right;">6/25/14</p>	

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/09/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>
---	---

(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 323	<p>Continued From page 32</p> <p>of her w/c. Alarm intact, no injuries noted. Two person extensive assist transfer back to w/c...</p> <ul style="list-style-type: none"> <li>- Care Plan updated - Yes.</li> <li>- Recent admit s/p CVA with left sided deficit.</li> <li>- How long since the resident had last voided - 2 hours.</li> <li>- Interventions initiated immediately after fall - Assessed for new onset of pain, assisted resident up with 2 person extensive assist and assisted back into w/c...</li> <li>- Recommendations to prevent further falls - Therapies to evaluate and treat as indicated.</li> </ul> <p>Summary of interview with witness(es) - NA</p> <p>- Root Cause Conclusion - Resident's poor safety awareness and general weakness secondary to CVA with left sided deficit."</p> <p>* The Fall CP, initiated on 11/6/13, documented: Neuro[ological] checks per facility protocol; therapy to continue tx [treatment] per MD orders for safety, strength, and cognition; and place call light within easy reach of resident.</p> <p>* Fall Risk Evaluation, dated 11/7/13, documented: A score of 12 or above indicated the resident was at high risk for falls, the resident scored a "15."</p> <p>* The Fall CP, initiated on 12/6/13, documented: low bed; use simple "yes/no" phrases and questions; and evaluate effectiveness and monitor for side effects of drug.</p> <p>* An I&amp;A Report, initiated on 12/7/13 at 7:00 PM, and completed on 5/7/14:</p> <ul style="list-style-type: none"> <li>- "Resident was witnessed to have slid out of w/c to floor while in her room. Resident was assisted up from floor with 2 person extensive assist...</li> <li>- Care Plan updated - Yes.</li> </ul>	F 323		
-------	--	-------	--	--

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>05/09/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>
---	---

(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 323	<p>Continued From page 33</p> <ul style="list-style-type: none"> <li>- How long since the resident last voided - unknown [resident] incontinent.</li> <li>- Interventions initiated immediately after fall - assisted resident up from floor with a 2 person extensive assist. Assessed resident for injuries, none noted. Resident shows no s/sx of any pain.</li> <li>- Family/Responsible party notified - No.</li> <li>- Recommendations to prevent further falls (document interventions below and on the Care Plan) - Therapy to eval[uate] for positioning.</li> <li>- Summary of Interview of witness(es) - Resident was noted to have slid out of w/c to floor.</li> <li>- Root Cause Conclusion - Resident's muscular deficit and poor cognition r/t CVA."</li> </ul> <p>NOTE: The resident's Fall CP was not evaluated after the fall on 12/7/14, to determine the effectiveness of the current interventions. Additionally, the facility failed to modify and replace current interventions in place.</p> <p>* An I&amp;A Report, initiated on 1/3/14 at 1:30 PM, and completed on 5/7/14, documented:</p> <ul style="list-style-type: none"> <li>- "Resident attempted to transfer unassisted from w/c to bed while friend in her room. Turned to sit on bed and sat on the floor. CNA heard the noise and entered the room...</li> <li>- Care Plan updated - Yes.</li> <li>- Bed was in the low position.</li> <li>- Both 1/2 side rails were up.</li> <li>- Interventions initiated immediately after the fall - Neuro checks initiated per facility protocol. Assessed resident for any new injuries, none noted...</li> <li>- Recommendations to prevent further falls - Non skid foot wear.</li> <li>- Summary of interview with witness(es) - As stated previously.</li> <li>- Root Cause - Resident got up from w/c turned</li> </ul>	F 323		
-------	---	-------	--	--

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>05/09/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>
---	---

(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 323	Continued From page 34 to sit on bed and sat onto the floor rather than the edge of bed."  NOTE: It was difficult to determine how the resident would be able to transfer successfully from the w/c to the bed with the side rails up and the bed in the low position, the resident was 5 feet 9 inches tall. Additionally, the resident's Fall CP was not reviewed and revised after the fall on 1/3/14, to determine the effectiveness of the current interventions.  * An I&A Report, initiated on 2/5/14 at 9:00 AM, and completed on 5/7/14, documented: - "Following the AM meal [breakfast], resident self propelled w/c back to her room and attempted to transfer to her bed and fell onto the floor. - Care Plan updated - Yes. - An alarm was being used for the resident, the alarm was in place, but the alarm was not turned on. - The resident's bed was in the low position and siderails were up. - Interventions initiated immediately after fall - Assessed res[ident] for any new onset of pain..., assessed for any injuries..., initiated Neuro checks... - Recommendations to prevent further falls - Educate staff on checking that alarms are in place and turned on. Staff to anticipate needs i.e.: toileting pre and post meals. - How long since the resident last voided - 1 hour. - Summary of interviews with witness(es) - NA."  NOTE: It was difficult to determine how the resident would be able to transfer successfully from the w/c to the bed with the side rails up and the bed in the low position, the resident was 5 feet 9 inches tall.	F 323		
-------	---	-------	--	--

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>05/09/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>
---	---

(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 323	<p>Continued From page 35</p> <ul style="list-style-type: none"> <li>* The Fall CP, initiated 2/5/14, documented: provide education to staff to ensure that alarms are in place per plan of care and Neuro checks per facility protocol. Both interventions listed above had a line written through them and "D/C," (discontinued); however, there was not a date to indicate when the interventions had been discontinued.</li> <li>* The Fall CP, initiated on 2/18/14, documented: fall mat to left side of bed.</li> <li>*An I&amp;A Report, initiated on 3/23/14 at 10:00 PM, and completed on 4/1/14, documented:             <ul style="list-style-type: none"> <li>- "...heard resident calling for help, opened door of resident's room to find resident lying on floor by sink...left leg appeared displaced, resident stated 'ouch, ouch, ouch' and pointing [to her left leg]. Resident transported to local hospital.</li> <li>- Care Plan updated - Yes.</li> <li>- An alarm was being used for the resident, the alarm was in place, but the alarm was not turned on.</li> <li>- How long since the resident last voided - immediately.</li> <li>- Additional comments - Resident at times is compulsive and evidently ambulated independently to the bathroom, possibly disabled alarm system, unknown why resident did not use call light as she has in the past when waiting to use the bathroom at night.</li> <li>- Interventions initiated immediately after the fall - Resident was stabilized with a CNA at side from the time of the incident until transported via ambulance from the facility.</li> <li>- Recommendations to prevent further falls - Upon return from the hospital, the resident will</li> </ul> </li> </ul>	F 323		
-------	--	-------	--	--

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/09/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>		
(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 323	<p>Continued From page 36</p> <p>have 30 minute checks for needs and to check alarm placement.</p> <p>- Summary of interview with witness(es) - CNA had checked on resident about 10 min[utes] prior to event and res[ident] appeared to be asleep in bed.</p> <p>- Root Cause Conclusion, Resident had always used call light to ask for assist to bathroom. On this occasion, she did not ask and evidently go up by herself to use the bathroom and was on her way to the sink to wash her hands when she fell.</p> <p>- Cause of injury, It is unknown to me if there are preexisting conditions to this hip fracture, but resident was in evident distress post fall."</p> <p>NOTE: On 3/23/14, at 10:15 PM, the resident was transported to a local hospital for evaluation and treatment of her left hip. The resident was later admitted to the hospital.</p> <p>* X-ray results, dated 3/24/14, were reviewed and documented the following, "Acute comminuted (a fracture in which the bone has broken into several pieces) intertrochanteric left hip fracture with mild shortening." The resident required surgical intervention to repair the left hip fracture.</p> <p>* The resident's Discharge from the hospital, dated 3/28/14, documented the following, "The patient is a...female with a history of right MCA stroke and residual left hemiparesis and expressive aphasia. She initially had a fall with fracture of the left hip in December of 2013, but could not have any surgical procedure as she recently had a stroke during the same time period. She presented to the Emergency Room [on 3/23/14] after suffering a fall with a new fracture superimposed to recent fracture, intertrochanteric..."</p>	F 323		

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>05/09/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>
---	---

(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 323	<p>Continued From page 37</p> <p>NOTE: The resident was readmitted to the facility on 3/28/14.</p> <p>* The Fall Risk Evaluation, dated 3/28/14, documented: A score of 12 or above indicated the resident was at high risk for falls, the resident scored a "19."</p> <p>* The Fall CP, initiated on 3/28/14, documented: pressure alarm and 30 min[ute] [checks]. (This intervention was already on the care plan with an initiated date of 10/27/13).</p> <p>*Physical Therapy Evaluation, dated 3/31/14, documented: "Resident referred to PT following a hospitalization for a [Left] hip fracture and presents now with TTWB (Toe Touch Weight Bearing)to Left LE [lower extremity] and very dependent with transfers and mobility. PT interventions to include transfer training in light of Wt (weight) bearing restrictions to patient..."</p> <p>* Occupational Therapy Evaluation, dated 3/31/14, documented: " Pt (patient) was a long term care resident but due to fall and hip fx (fracture) she has declined in condition and now requires OT to [increase independence with] self care and return to her prior level of function..."</p> <p>NOTE: The ground level fall on 3/23/14 resulted in ADL decline and ability to ambulate. Prior to the fall, the resident required extensive assistance of one person for ADLs and limited assistance of one person for ambulation; after the fall, the resident required assistance of two people for ADL assistance and she was not able to ambulate due to her hip fracture and TTWB.</p>	F 323		
-------	---	-------	--	--

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/09/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>		
(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 323	<p>Continued From page 38</p> <p>On 5/9/14 at 12:00 PM, the MCO, Interim DNS, and SDC were interviewed. The surveyor asked the MCO why the Fall CP was not reviewed and revised after each fall to include increased supervision. The MCO said she did not have an answer for why that was not done, but would look into it. The MCO stated she and the RVP, in December 2013, had identified that the facility had concerns related to resident falls and were working with facility staff to decrease the facility's number of falls. No additional information was provided to resolve this concern.</p> <p>The facility failed to implement care plan interventions or provide adequate supervision to reduce Resident #4's risk for falls. The resident was harmed when she fell and fractured her left hip.</p> <p>2. Resident #1 was admitted to the facility with multiple diagnoses to include aftercare for healing traumatic fracture of the hip, abnormality of gait, congestive heart failure, and dementia.</p> <p>The resident's most recent Admission MDS, dated 4/4/14, coded the following:</p> <ul style="list-style-type: none"> <li>- Moderately impaired cognition.</li> <li>- Short Term/ Long Term memory, "OK."</li> <li>- Extensive assist of one person for transfers, dressing, toilet use, and bathing.</li> <li>- Independent with bed mobility.</li> <li>- Functional limitation in range of motion on both sides.</li> <li>- Restraints in bed, bed rail - "none."</li> </ul> <p>NOTE: The resident's Quarterly MDS was coded incorrectly under P0100, Physical Restraints, and did not trigger a Care Area Assessment to be considered (CAA) for restraints; consequently</p>	F 323		

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>05/09/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>
---	---

(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 323	<p>Continued From page 39</p> <p>there were no areas on the resident's care plan related to the use of side rails.</p> <p>Resident #1's bed was observed to have side rails on the bed and in the upraised position on 5/5/14 - 5/8/14 at 8:30 AM, 10:00 AM, 1:00 PM, and 3:00 PM.</p> <p>The resident's medical record was reviewed and it was determined the record did not include documentation that an evaluation for the use of siderails was completed to assess whether or not the siderails were safe for Resident #1 to use.</p> <p>3. Resident #4 was admitted to the facility on 10/25/13 and re-admitted on 3/28/14 with multiple diagnoses to include aftercare for fall with fracture, recent CVA, left-sided hemiplegia and expressive aphasia.</p> <p>Resident #4's most recent Quarterly MDS assessment, dated 4/7/14, coded the following:</p> <ul style="list-style-type: none"> <li>- Short Term/Long Term memory impairment.</li> <li>- Extensive assistance of two people for bed mobility, transfers, dressing, and toileting.</li> <li>- Walking in her room, locomotion on and off the unit did not occur.</li> <li>- Functional limitation and impairment of upper and lower extremity on one side.</li> <li>- Restraint in bed, bed rail - "none."</li> </ul> <p>NOTE: The resident's Quarterly MDS was coded incorrectly under P0100, Physical Restraints, therefore it did not trigger a Care Area Assessment to be considered (CAA) for restraints; consequently there were no areas on the resident's care plan related to the use of side rails.</p>	F 323		
-------	---	-------	--	--

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 05/09/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  PAYETTE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1019 THIRD AVENUE SOUTH PAYETTE, ID 83661
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 323	<p>Continued From page 40</p> <p>Resident #1's bed was observed to have side rails on the bed and in the upraised position, on 5/5/14 - 5/8/14 at 8:40 AM, 10:10 AM, 1:10PM, and 3:00 PM.</p> <p>A Device Evaluation form, dated 10/27/13, documented:</p> <ul style="list-style-type: none"> <li>* "Cognitive Status - Memory impaired, decreased safety awareness, and short attention span.</li> <li>* Bed mobility - Assisted mobility.</li> <li>* Transfer - Assisted transfer.</li> <li>* Functional Limitation - Left arm, hand, leg, and foot, flaccid.</li> <li>* Balance/Posture - Impaired balance, leans to the left, flaccidity, and uncontrolled body movements.</li> <li>* Fall History - Fell within the last 30 days.</li> <li>* Side Rail evaluation = If side rails are in use, they are to be considered a positioning device. The summary of risk factors and interventions attempted to date, on page 2 of this form was blank.</li> </ul> <p>NOTE: Per the facility's policy and the directions on the Device Evaluation Form, the side rails were supposed to be evaluated quarterly. The quarterly evaluation portion of the form was blank. Resident #4's side rails had not been assessed since 10/27/13 or 6 months prior to survey. Additionally, it could not be determined the side rails had ever been assessed for safety.</p> <p>On 5/9/14, at 9:20 AM, the MCO, DNS, and SDC were interviewed related to the above concern. The MCO stated the maintenance supervisor had assessed the side rails throughout the building for safety to include gap assessment and whether the bed itself was safe for use; however, she</p>	F 323		
-------	---	-------	--	--

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 05/09/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  PAYETTE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1019 THIRD AVENUE SOUTH PAYETTE, ID 83661
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 323	<p>Continued From page 41</p> <p>stated the side rails in use for Resident #1 and #4 had not been individually assessed for safety.</p> <p>4. Resident #3 was admitted to the facility on 7/21/08 and readmitted on 3/11/14 with multiple diagnoses including rehabilitation, aftercare healing of pathologic fracture of the left lower leg, muscular wasting and disuse atrophy, abnormality of gait and unspecified osteoporosis.</p> <p>The resident's Annual MDS Assessment, dated 1/4/14, documented the following: *Resident was cognitively intact with a BIMS Score of 15. *Extensive assistance of one person for bed mobility, transfer, dressing, toilet use and bathing. *Walking in room and corridor did not occur. *Height = 64" (5'5"), Weight = 277# (pounds).</p> <p>The resident's most recent Quarterly MDS Assessment, dated 4/6/14, documented the following: *Cognitively intact with a BIMS Score of 13. *Extensive assistance of two 2+ persons for bed mobility, transfers, dressing, toilet use and bathing. *Walking in room and corridor did not occur. *Height = 64" (5'5"), Weight = 262 #.</p> <p>The CAA (Care Area Assessment) Worksheet, dated 1/4/14, documented in the analysis of</p>	F 323		
-------	--	-------	--	--

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>05/09/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>		
(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 323	<p>Continued From page 42</p> <p>findings for the ADL Functional/Rehabilitation Potential, "Resident has self care deficit r/t weakness to BLE (bilateral lower extremities). Resident states she needs extensive assist for her ADL's r/t her BLE that she has weakness and pain and cannot lift her legs for self transferring...needs extensive assist for lower body..."</p> <p>The resident's Fall Care Plan (CP), initiated on 6/23/09, documented:            *During transfers ensure client has appropriate fitting shoes or non skid socks to prevent slipping.            *Instruct/teach client to wait for assistance and educate on fall preventions such as setting wheelchair brakes, use walker, etc. PRN.            *Monitor frequently for safety issues, keep room clean and clutter free.            *Use gait belt when transferring, as needed."            (This intervention was discontinued on 1/18/14).</p> <p>The resident's Nursing Assistant Care Card (undated) documented the resident needed extensive assistance of 1-2 persons for transfers and assistance of 1 person for toilet use.</p> <p>An Incident/Accident Report (I&amp;A), initiated on 3/7/14 at 12:00 PM and completed on 3/26/14 at 11:52 AM, (refer to F-225 as it relates to investigations) documented:            *Event: Resident lowered to floor.            *Injury: Fracture (left ankle).            *Transported out of center: Yes.            *Admitted: Yes.            *Date: 3/7/14.            *Transferred to hospital: Yes.            *Care Plan updated: Yes.            *Footwear/Equipment at time of fall: Shoes, socks, walker, wheelchair, walker.</p>	F 323		

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>05/09/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>
---	---

(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 323	<p>Continued From page 43</p> <p>*Did fall occur during a transfer: Yes.</p> <p>*Use of gait belt: No.</p> <p>*Activity engaged in at the time of fall: Resident had just finished voiding on BSC (bedside commode) when a CNA was assisting the resident up from commode and back into wheelchair.</p> <p>*Interventions initiated immediately after fall: Assisted to bed with use of Hoyer mechanical lift. Stabilized left ankle with pillows. Ice pack applied to left ankle. Pain medication given.</p> <p>*Recommendations to prevent further falls: Hoyer lift for all transfers.</p> <p>*Summary of interview with witness: CNA was assisting res[ident] up from BSC. Bottom of pant covered the bottom of resident's shoes. CNA and resident were attempting to pull pants up when resident began to slip down. Resident was then lowered to the floor with assistance.</p> <p>*Root cause conclusion: Resident's pants extended below her feet causing her to slip. Resident has history of osteoporosis, poor neuromuscular strength and morbid obesity.</p> <p>*Cause of injury: Pants became entangled around bottom of feet. Morbid obesity with long history of osteoporosis.</p> <p>On 5/6/14 at 10:10 AM, Resident #3 commented to the surveyor regarding her fall. She stated it happened on day shift, that CNA #1 was behind her and helped her off the BSC. She stated all of a sudden she went down and the CNA also went down. The resident stated she went to the hospital and had surgery on her left foot.</p> <p>On 5/8/14 at 1:15 PM, Resident #3 was interviewed. She stated before the fall she could stand without problems but was using a wheelchair instead of walking. She could</p>	F 323		
-------	--	-------	--	--

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>05/09/2014</b>	
NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>		
(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 323	<p>Continued From page 44</p> <p>physically do whatever she wanted, was able to tidy up her room, and enjoyed being involved with the activities program. She stated she didn't know what caused her fall. She said she didn't need pain medication before the fall but now needs pain medication "3-4 times per day." She stated that "some days the pain is worse than others."</p> <p>NOTE: Record review of the resident's MAR, dated February 2014, documented the resident did not receive any PRN pain medication. However, the MAR, dated March 2014, after the resident fell and fractured her left ankle, documented she requested PRN pain medication on March 16, 17, 18, 23, 24, and 30. The MAR, dated April 2014, documented the resident requested PRN pain medication a total of 18 times.</p> <p>Resident #3 stated she did not remember CNA #1 using a gait belt when transferring her from sitting to a standing position. She stated CNA #1 was behind her, and that she fell backwards on her.</p> <p>Resident #3 stated she is now bed bound and gets up for meals occasionally in the WC but then goes right back to bed. She stated "The fall has really messed up my whole life" due to pain and having to stay in bed. She stated she has "pain most of the day and night."</p> <p>On 5/8/14 at 1:45 PM, CNA #1 was interviewed regarding Resident #3's fall. She stated Resident #3 could stand and pivot before the fall. She stated the resident "was fairly mobile and was able to do a lot on her own." She stated the resident combed her own hair, put on cosmetics, attended numerous activities, washed the front</p>	F 323		

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/09/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>
---	---

(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 323	<p>Continued From page 45</p> <p>parts of her body and private areas, and dried herself.</p> <p>Before the fall, CNA #1 stated the resident was a one person assist and that another aide had put her on the BSC (bedside commode). CNA #1 responded when the resident put on her call light. She stated Resident #3's walker was in front of the resident and that the resident held on to the walker as she stood up. The resident's WC was locked on the resident's right side, CNA #1 stated, and she was between the BSC and the resident. The resident lost her balance and landed on her, CNA #1 stated, as she was pulling the resident's pants up and the resident lost her balance. She stated she thought the resident's left leg bent backwards when she went to the floor. CNA #1 stated she thought the resident was standing on a string but didn't think the resident's pants were under her feet.</p> <p>When asked if she used a gait belt (device used for transferring people from one position to another) with Resident #3, CNA #1 stated she normally used a gait belt with most resident's but didn't have one large enough at the time.</p> <p>The facility's Policy and Procedure for Safe Resident Handling Equipment documented, "A Gait Belt is used with patients who can safely ambulate with assistance and/or perform greater than or equal to 50% of lift/transfer with stand pivot assistance with one staff member."</p> <p>On 5/9/14 at 9:15 AM, CNA #4 stated she worked with the resident before and after her fall on evening shift. CNA #4 stated she had noticed a change in Resident #3's attitude after the fall, who she said no longer wanted to get out of bed or</p>	F 323		
-------	--	-------	--	--

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>05/09/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>
---	---

(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 323	<p>Continued From page 46 shower, "usually because of pain."</p> <p>On 5/9/14 at 10:20 AM, the NPE and the MCO were made aware of the above concerns related to the resident's fall. The surveyor asked why the gait belt was discontinued on the resident's Fall Care Plan on 1/18/14. The MCO stated the DNS at the time discontinued the gait belt and stated, "I can't speak to that."</p> <p>Prior to the fall on 3/7/14, the resident was able to stand and pivot, helped with her activities of daily living, attended numerous activities and did not request PRN pain medication.</p> <p>After the fall, the resident had a decrease in her daily function, was non weight bearing and mainly stayed in bed. She had a change in attitude and does not want to get out of bed due to an increase in pain. She is not able to attend the activities program. Additionally, the resident stated the fall "really messed up her whole life due to pain and having to stay in bed."</p> <p>Prior to the fall on 3/7/14, the resident did not request PRN pain medication, however, since the fall the resident has requested PRN pain medication on a regular basis.</p> <p>The facility failed to identify interventions to replace the gait belt when it was discontinued from the care plan. CNA #1 stated she normally used a gait belt but didn't have one large enough for Resident #3 at the time of the 3/7/14 transfer, fall, and fracture. The resident was harmed due to the facility's failure to ensure the resident was safe when being transferred.</p> <p>Additionally, Resident #3's bed was observed to</p>	F 323		
-------	--	-------	--	--

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 05/09/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  PAYETTE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1019 THIRD AVENUE SOUTH PAYETTE, ID 83661
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 323	<p>Continued From page 47</p> <p>have side rails on the bed and in the upraised position throughout the survey on 5/5/14 - 5/9/14.</p> <p>The resident's medical record was reviewed and it was determined the record did not include documentation that the use of side rails had been assessed to be safe for this resident.</p> <p>On 5/9/14 at 11:45 AM, the NPE was interviewed regarding the side rail restraint evaluation. The NPE stated, "The floor nurse had assessed it incorrectly."</p> <p>5. Resident #5 was admitted to the facility on 1/26/11 with diagnoses including unspecified peripheral vascular disease, bipolar I disorder, depressive disorder and anxiety.</p> <p>Resident #5's bed was observed to have a side rail on the bed in the upright position throughout the survey on 5/5/14 - 5/7/14.</p> <p>The resident's medical record was reviewed and it was determined the record did not include documentation that the use of side rails had been assessed to be safe for this resident.</p> <p>On 5/8/14 at 3:10 PM, the NPE was interviewed regarding the side rail restraint evaluation. The NPE stated, "I do not see that the side rail has been assessed to be safe."</p> <p>On 5/8/14 at 4:50 PM, the Administrator, MCO and NPE were made aware of the above side rail issues. No further documentation was provided.</p>	F 323		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS	F 328		

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/09/2014</b>	
NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>		
(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	<p>Continued From page 48</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record reviews and staff interviews, it was determined the facility failed to ensure a resident using oxygen had a physician's order for oxygen and that the oxygen was at the correct liter flow. This was true for 2 of 9 (#1 &amp; #8) sampled residents reviewed for oxygen therapy. This deficient practice created the potential for more than minimal harm should residents have a drop in oxygen saturations causing them to become anxious, confused and experience respiratory distress. Findings included:</p> <p>1. Resident #1 was admitted to the hospital with multiple diagnoses to include chronic airway obstruction, CHF (Congestive Heart Failure), A-fib (Atrial Fibrillation), and anemia.</p> <p>The resident's most recent Admission MDS, dated 4/4/14, coded: - Moderately impaired cognition. - Extensive assist of one person for transfers, dressing, toilet use, and bathing. - Functional limitations (impairment) in ROM on</p>	F 328	<p>F328</p> <p>Resident #1 was assessed by a licensed nurse on 5/6/14 with no adverse effects from use of O2 noted. The MD was notified of the assessment findings on 5/6/14 by the licensed nurse and an order for oxygen therapy was obtained and initiated.</p> <p>RN #2 was re-educated by the Nurse Practice Educator related to oxygen administration and following physician orders on 6/10/14.</p> <p>Resident #8 was assessed by licensed nurse on 6/13/14 for any adverse effect related to the lack of documentation of changing of oxygen tubing, filter, and humidified with none noted. The MD was notified of the incident by licensed nurse on 6/13/14 with no new orders obtained.</p>	

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>05/09/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>
---	---

(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	<p>Continued From page 49</p> <p>both sides.</p> <ul style="list-style-type: none"> <li>- Shortness of breath or trouble breathing with exertion and lying flat.</li> <li>- Special treatments - wears oxygen.</li> </ul> <p>* The resident's May 2014 All Active Orders were reviewed and did not include an order for oxygen.</p> <p>* The resident's May 2014 MAR and TAR were reviewed and did not document the resident was receiving oxygen.</p> <p>* The resident's Altered Respiratory Status CP, dated 3/28/14, documented the following under Interventions:</p> <ul style="list-style-type: none"> <li>- Lung sounds per order and PRN.</li> <li>- Obtain oxygen saturation levels per order and PRN. Notify physician PRN sats less than 90%.</li> <li>- Provide oxygen as ordered.</li> <li>- Replace oxygen humidifier PRN.</li> </ul> <p>* On 5/5/14 at 8:35 AM, the resident was observed wearing oxygen via nasal cannula at 4 LPM while eating breakfast in the dining room.</p> <p>* On 5/6/14 at 8:35 AM, the resident was observed eating his breakfast in the dining room with his oxygen tubing hanging around his neck and not in his nose. The oxygen buddy was set a 4 LPM.</p> <p>* On 5/6/14 at 9:55 AM, the resident was observed lying down on his bed without his oxygen on.</p> <p>* On 5/6/14 at 9:55 AM, RN #2 was asked what the resident's oxygen liter flow rate should be. RN #2 stated she was not sure and would need to look it up. She looked it up on the computer using Point Click Care and determined it was supposed to be at 3 LPM per his previous Admission. The</p>	F 328	<p>2. Other residents with the potential to be affected.</p> <p>A review of residents who require oxygen administration was completed by Director of Nursing on 6/25/14 to ensure that there is and MD order for oxygen in place, the oxygen is administered per MD order, and that oxygen tubing, filters, and humidifier are changed per MD order.</p> <p>Clarifications were obtained as needed.</p> <p>3. Systemic change</p> <p>Nursing staff were re-educated by the Nurse Practice Educator on 6/25/14 the medication and treatment administration policy including the need to obtain orders for oxygen administration in non-emergency situations and the need to sign treatment records after completion and with oxygen tubing, filter, and humidifier change and oxygen administration.</p>	
-------	--	-------	---	--

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>05/09/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>
---	---

(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	<p>Continued From page 50</p> <p>surveyor asked RN #2 if the oxygen should be on the resident's MAR. RN #2 looked at the resident's MAR, confirmed the oxygen was not on the MAR and stated it should be. RN #2 then reviewed the resident's May 2014 All Active Orders and stated the resident did not have a current order for oxygen.</p> <p>* At 10:05 AM, the surveyor asked RN #2 to accompany the surveyor to the resident's room and to bring the pulse oximeter. The resident was observed to be without his oxygen. RN #2 checked the resident's oxygen on room air. The resident's room air saturation was initially 78% and after about 1 minute his saturation registered at 82%. The surveyor asked the resident if he felt like he was breathing adequately. The resident said, "I think so," and reached up to feel for his oxygen tubing in his nose which was not there. RN #2 assisted the resident with placing his nasal cannula in his nose. The resident's oxygen saturation increased to 90% within 15-30 seconds.</p> <p>* At 10:10 AM, RN #2 stated she had called the Physician and received an order for the resident to be on oxygen 3 LPM via nasal cannula.</p> <p>On 5/9/14 at 9:20 AM, the MCO, DNS, and SDC were interviewed. The MCO and DNS stated they were already aware of the situation as RN #2 had reported it to them on 5/6/14. No further information was provided to resolve this concern.</p> <p>2. Resident #8 was admitted to the facility on 4/9/12 with multiple diagnoses which included congestive heart failure, osteoporosis, and atrial fibrillation.</p> <p>Resident #8's Recapitulation Orders for April 2014 documented:</p>	F 328	<p>4. Ongoing Audits</p> <p>Beginning the week of 6/25/14 an audit of 3 residents requiring oxygen administration will be completed by the Director of Nursing or designee to ensure that oxygen administration, care, and cleaning is completed per order weekly X4 weeks and then monthly X2 months. The results of these audits will be reported to the Performance Improvement Committee for review monthly X3 months or until resolved with remedial measures implemented as needed. The Director of Nursing is responsible for monitoring and follow up.</p>	6/25/14
-------	---	-------	--	---------

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/09/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>		
(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 51 **Clean oxygen concentrator filter every week - Night Shift Specific days of week: Wed" with a start date of 1/18/13. **Change humidifier bottle on oxygen concentrator weekly and as needed. - Night Shift Specific days of week: Wed" with a start date of 1/18/13. **Change humidifier tubing weekly. - Night Shift Specific days of week: Wed" with a start date of 1/18/13. **Change oxygen tubing weekly. - Night Shift Specific days of week: Wed" with a start date of 1/18/13.  The MAR did not document the oxygen concentrator filter was cleaned weekly, the humidifier bottle was changed on the oxygen concentrator weekly, the humidifier tubing was changed weekly or the oxygen tubing was changed weekly for the month of April 2014.  On 5/8/14 at 2:20 PM, the NPE was interviewed regarding the missing documentation on the MAR for April 2014. The NPE stated, "I see the same," pertaining to the missing documentation.  On 5/8/14 at 4:50 PM, the Administrator, MCO and NPE were made aware of the missing documentation on the MAR for April 2014. No further information was provided.	F 328			
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE  The facility must ensure that it is free of medication error rates of five percent or greater.	F 332			

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>05/09/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>		
(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 332	<p>Continued From page 52</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to maintain a medication error rate of less than 5%. This was true for 3 of 30 medications (10%) which affected 2 of 3 random residents (RR) (#s 11 &amp; 12) observed during the medication pass. This failed practice created the potential for less than optimum benefit from prescribed medications that were not administered as ordered.</p> <p>1. Resident #11 was admitted to the facility with multiple diagnoses to include CHF, Coronary Artery graft, obstructive sleep apnea, and MRSA.</p> <p>On 5/7/14 at 8:40 AM, the resident was sitting in her room eating her breakfast. RN #3 asked the resident if she was ready for her morning medication.</p> <p>At 8:45 AM, RN #3 was observed as he poured, then administered the following 2 medications to RR #11: - CellCept (immunosuppressive) 500 mg, take 1 tablet by mouth three times every day. Take two hours apart from omeprazole and protonix. - Omeprazole 40 mg capsule DR, take 1 capsule by mouth every day.</p> <p>On 5/7/14 at approximately 10:00 AM, reconciliation of the aforementioned medications with the resident's recapitulation of Active Orders for May 2014 revealed the Cellcept was to be given two hours apart from the Omeprazole and the Omeprazole was to be given prior to the meal.</p> <p>On 5/7/14 at approximately 10:05 AM, RN #3 was</p>	F 332	<p>F332</p> <p>Residents affected</p> <p>Resident #11 discharged from Payette center on 5/14/14.</p> <p>Resident #12 was assessed by licensed nurse on 6/13/14 with no adverse effects noted related to swallowing the water rinse after Advair Diskus administration.</p> <p>The MD was notified of the incident on 6/13/14 by Director of Nursing with no new orders obtained.</p> <p>RN #3 was re-educated by the Nurse Practice Educator on 6/13/14 to ensure that Omeprazole is administered on an empty stomach 30 minutes prior to a meal and the dosing instructions for CellCept, and instructing the patient to spit out the water after rinsing mouth post Advair Diskus administration.</p> <p>2. Other residents with the potential to be affected</p> <p>The Director of Nursing or designee completed a medication pass observation and record review for</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>05/09/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>
---	---

(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 332	<p>Continued From page 53</p> <p>asked when the Omeprazole should be given per manufacturer's specifications. RN #3 stated the omeprazole should be given one hour before the meal. RN #3 was then asked to review the order for the CellCept. RN #3 stated it should not be given with the Omeprazole, it should be given two hours apart from the Omeprazole. RN #3 stated the night shift nurse had processed the order on 5/6/14 and added it to the MAR, but did not include the information related to administration.</p> <p>On 5/7/14 at 10:30 AM, the MCO and DNS were informed of the issue. No other information was received from the facility which resolved the issue.</p> <p>2. RR #12 was admitted to the facility with multiple diagnoses to include essential hypertension, aftercare for pathologic fracture of lower leg, and muscular wasting and disuse atrophy.</p> <p>On 5/7/14 at 8:50 AM, RN #3 was observed to administer Advair Diskus 100/50, one inhalation twice a day, to RR #12. After the resident inhaled the powder through her mouth RN #3 gave the resident a cup of water to rinse her mouth. The resident was observed to take a drink of water, swish it around in her mouth and then swallow it. RN #3 took the resident's cup and walked away. The RN did not educate the resident related to the manufacturer's specification; rinse mouth without swallowing to prevent oral candidiasis (yeast).</p> <p>On 5/7/14 at 8:50 AM, the surveyor asked RN #3 if it was acceptable for the resident to have swished and swallowed the water after using the Advair Diskus, or if the resident should have</p>	F 332	<p>current residents on or before 6/25/14 to ensure that medications are accurately transcribed and administered, and that special instructions and standards of practice are followed.</p> <p>3. Systemic Change</p> <p>Licensed nurses were re-educated by the Nurse Practice Educator on 6/25/14 the medication and treatment administration policy including ensuring that Medication orders are accurately transcribed and include dosing instructions, and that special instructions and standards of practice are followed.</p> <p>4. Ongoing audits</p> <p>Beginning the week of 6/25/14, 2 medication pass observations will be completed by the Director of Nursing or designee to ensure that medications are transcribed and administered per order and that special instructions and standard of practice are followed weekly X4 weeks and then monthly X2 months. The results of these audits will be reported to the performance Improvement Committee for review monthly X3 months or until resolved with remedial measures implemented as needed. The Director</p>	
-------	--	-------	---	--

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 05/09/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  PAYETTE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1019 THIRD AVENUE SOUTH PAYETTE, ID 83661
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 332	Continued From page 54 rinsed and spit. RN #3 stated the resident should have rinsed and spit.  On 5/7/14 at 10:30 AM, the MCO and DNS were informed of the issue. No other information was received from the facility which resolved the issue.	F 332	of Nursing is responsible for monitoring and follow-up.	6/25/14
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to maintain accurate, complete and organized clinical records on each resident. This was true for 3 of 10 sampled residents (#'s 2, 3, & 4 ) reviewed for clinical records. This deficient practice increased the risk for medical decisions to be based on incomplete or inaccurate information and increased the risk for complications due to inappropriate care and/or interventions. Findings included:	F 514	F514  Resident affected  Resident #2 was assessed by the licensed nurse on or before 6/13/14 for any adverse effect related to incomplete documentation with none noted. MD was notified of review by the MDS nurse on or before 6/13/14 with no new orders noted.  Resident #3 discharged from Payette Center on 5/26/14.  Resident #4 was assessed by the MDS nurse or designee on 6/17/14 with no adverse effect related to incomplete documentation noted. MD notified of review by MDS nurse on or before 6/17/14 with no new orders noted.  2. Other residents with the potential to be affected	

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/09/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>
---	---

(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 514	<p>Continued From page 55</p> <p>1. Resident #2 was admitted to the facility with multiple diagnoses to include abnormality of gait, muscular wasting and disuse atrophy, and intellectual disabilities.</p> <p>Resident #2's April 2014 TAR documented, a licensed nurse was to conduct weekly skin checks each Wednesday during the evening shift.</p> <p>Resident #2's April 2014 TAR did not document the resident received skin checks on 4/23/14 and 4/30/14.</p> <p>2. Resident #4 was admitted to the facility on 10/25/13, and re-admitted on 3/28/14, with multiple diagnoses to include aftercare for fall with fracture, recent CVA, left-sided hemiplegia and expressive aphasia.</p> <p>Resident #4's April 2014 TAR documented a licensed nurse was to conduct weekly skin checks each Tuesday during the day shift.</p> <p>Resident #4's April 2014 TAR did not document the resident had received skin checks for the entire month of April 2014.</p> <p>On 5/8/14 at 4:50 PM, the MCO, DNS, and SDC were interviewed related to skin checks not being completed. The MCO and SDC said they were certain the skin checks were completed, but not documented by the nurse. No additional information was provided to resolve this concern.</p> <p>3. Resident #3 was admitted to the facility on 7/21/08 and readmitted on 3/11/14 with multiple diagnoses including rehabilitation, aftercare</p>	F 514	<p>Resident MAR's and TAR's were reviewed for the last 30 days by the Director of Nursing or designee on or before 6/25/14 MD notifications completed as indicated by the licensed nurse on or before 6/25/14 with no new orders obtained.</p> <p>3. Systemic change</p> <p>Nursing staff were re-educated by the Nurse Practice Educator on 6/25/14 regarding the need to ensure medications, treatments, and skin checks are completed as ordered, and ensuring that documentation is completed prior to the end of the shift per facility policy.</p>	
-------	--	-------	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/09/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>
---	---

(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 514	<p>Continued From page 56</p> <p>healing of pathologic fracture of the left lower leg, muscular wasting and disuse atrophy, abnormality of gait and unspecified osteoporosis.</p> <p>The Recapitulation Orders, dated 3/12/14, documented the following:                      *Wound dressing site to be observed every shift every day;                      *Float heels with pillows while in bed every shift every day;                      *Pressure reducing mattress to bed;                      *Pressure redistribution cushion to chair;                      *Trapeze over bed for bed mobility; and,                      *Weekly skin assessments by LN on Tuesday.</p> <p>The March 2014 TAR (Treatment Administration Record) did not document Resident #3's heels were floated on:                      *Day shift - 3/12, 3/19 and 3/20.                      *Evening shift - 3/25.                      *Night Shift - 3/12, 3/14-15, 3/20-22, 3/27-29.</p> <p>The March 2014 TAR did not document Resident #3's wound dressing site was observed every shift:                      *Day shift - 3/12, 3/19, and 3/20.                      *Evening shift - 3/25.                      *Night shift - 3/12, 3/14-15, 3/20-22, and 3/27-29.</p> <p>The Recapitulation Orders documented an order, dated 3/26/14, to ensure an off loading podus boot was in place every shift, everyday.</p> <p>The April 2014 MAR did not document that the off loading podus boot was in place every shift as ordered for the following:                      *Evening Shift - 4/28.                      *Night Shift - 4/3-5, 4/10-12, 4/17-18, 4/24-25 &amp; 4/30.</p>	F 514	<p>4. Ongoing audits</p> <p>Beginning the week of 6/25/14 an audit of the MAR's and TAR's will be completed by the Director of Nursing or designee to ensure that documentation of medication and treatment administration per MD order weekly X4 weeks and then monthly X2 months. The results of these audits will be reported to the Performance Improvement Committee for review monthly X3 months or until resolved with remedial measures implemented as needed. The Director of Nursing is responsible for monitoring and follow up.</p>	6/25/14
-------	--	-------	---	---------

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 05/09/2014
NAME OF PROVIDER OR SUPPLIER  PAYETTE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1019 THIRD AVENUE SOUTH PAYETTE, ID 83661		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 514	<p>Continued From page 57</p> <p>Additionally, the April 2014 MAR did not document the resident's heels were floated on: *Evening shift - 4/28. *Night Shift - 4/3-5, 4/10-12, 4/17-18, 4/24-25 &amp; 4/30.</p> <p>The April 2014 MAR also documented the wound dressing site was not observed every shift for the following: *Day shift - 4/10, &amp; 4/12. *Evening shift - 4/28. Night shift - 4/3-5, 4/10-12, 4/17-18, 4/24-25 &amp; 4/30.</p> <p>The Recapitulation Orders, dated 4/21/14, documented the following orders: *Check CMS (color, motion, sensation) to left lower extremity/foot/toes every shift - Every shift Everyday Assessment. *Remove podus boot to left foot/ankle every shift for a skin check under boot. Ensure boot is replaced and left heel is fully suspended - Every Shift Everyday Assessment.</p> <p>The April 2014 MAR did not document CMS checks or removal of the podus boot for the following: *Evening Shift: 4/28. *Night Shift: 4/24-25 &amp; 4/30.</p> <p>The May 2014 MAR did not document the resident's heels were floated on: *Evening shift - 5/6. *Night Shift - 5/2-3.</p> <p>The May 2014 MAR did not document the resident's Podus boot was in place during the following times: *Evening shift - 5/6.</p>	F 514		

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 05/09/2014
NAME OF PROVIDER OR SUPPLIER  PAYETTE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1019 THIRD AVENUE SOUTH PAYETTE, ID 83661		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	<p>Continued From page 58</p> <p>*Night shift - 5/2-3.</p> <p>The May 2014 MAR did not document the resident's wound dressing site was observed during the following times: *Evening shift - 5/6. *Night shift - 5/2-3.</p> <p>The May 2014 MAR did not document the resident's Podus boot to the left foot/ankle was removed and skin check performed under the boot, or that the boot was replaced and the left heel fully suspended during the following times: *Evening shift - 5/6. *Night shift - 5/2-3.</p> <p>The May 2014 MAR did not document CMS checks to the resident's lower extremity/foot/toes were completed during the following times: *Day shift: 5/3, *Evening shift: 5/6. *Night shift: 5/2-3.</p> <p>The May 2014 MAR did not document the resident's surgical incision wound received care every 12 hours during the following times: *5/3 - 8:00 AM. *5/6 - 8:00 PM.</p> <p>On 5/9/14 at 10:20 AM, the surveyor questioned the NPE regarding the missing data in documentation on the March, April and May 2014 TARs in which heels were not consistently floated, wound dressing site not observed every shift, CMS not performed, Podus boot not removed, Podus boot not offloaded or replaced and the left heel not fully suspended. The NPE confirmed the information was missing in the MARs and stated the "holes" were a "problem."</p>	F 514		

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

PRINTED: 06/04/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>05/09/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>
---	---

(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 514	<p>Continued From page 59</p> <p>The NPE stated she was responsible for the missing 4/28/14 documentation on the evening shift but could not explain the cause for the other missing documentation. She stated it looked like there was a "pattern."</p> <p>On 5/8/14 at 4:50 PM, the Administrator, MCO and NPE were made aware of the missing documentation. No further information was provided.</p>	F 514		
-------	---	-------	--	--

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001120</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  C <b>05/09/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>		
(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 annual federal recertification survey of your facility.  The surveyors conducting the survey were: Rebecca Thomas, RN, Team Coordinator Amy Barkley, RN, BSN	C 000	<p>“This Plan of Correction is prepared and submitted as required by law. By submitting this plan of correction Payette Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.”</p> <p>C 125 Refer to Federal POC F241</p> <p>C 175 Refer to Federal POC F225</p>	
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: Please refer to F241 as it relates to dignity.	C 125		
C 175	02.100,12,f Immediate Investigation of Incident/Injury  f. Immediate investigation of the cause of the incident or accident shall be instituted by the facility administrator and any corrective measures indicated shall be adopted.  This Rule is not met as evidenced by: Please refer to F225 as it relates to timely investigations.	C 175		
C 409	02.120,05,i Required Room Closet Space  i. Closet space in each sleeping	C 409		

RECEIVED  
JUN 18 2014  
FACILITY STANDARDS

Bureau of Facility Standards

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

TITLE

(X6) DATE

*Seeg Reed*, Administrator 6/17/14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001120</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/09/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>		
(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 409	Continued From page 1  room shall be twenty inches by twenty-two inches (20" x 22") per patient/resident. Common closets utilized by two (2) or more patients/residents shall be provided with substantial dividers for separation of each patient's/resident's clothing for prevention of cross contamination. All closets shall be equipped with doors. Freestanding closets shall be deducted from the square footage in the sleeping room.  This Rule is not met as evidenced by: Based on staff interview, it was determined the facility did not provide the required closet space of 20 inches x 22 inches, for 1 of 3 halls (the 100 hall) - all closets in rooms 101-120, 201 and 203.  On 5/8/14 at 2:00 PM, the Maintenance Supervisor indicated that a waiver would again be requested for the closets. All the closets in the 100 hall measured 36 inches wide and 24 inches deep. The closets had dividers separating them, which created individual closet space of 18 inches wide by 24 inches deep. The same was true of rooms 201 and 203.	C 409	C 409 Waiver requested	
C 747	02.200,01,e Individualized Resident Care Plan  e. Observing and evaluating the condition of each patient/resident and developing a written, individualized patient care plan which shall be based upon an assessment of the needs of each patient/resident, and which shall be kept current through review and revision;  This Rule is not met as evidenced by:	C 747	C 747 Refer to Federal POC F278	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001120</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/09/2014</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>
---	---

(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 747	Continued From page 2  Please refer to F-278 as it relates to MDS Assessments.	C 747		
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 F280 as it relates to revision of care plans.	C 782	C 782 Refer to Federal POC F280	
C 784	02.200,03,b Resident Needs Identified  b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Please refer to F-309 as it relates to highest practical care.	C 784	C 784 Refer to Federal POC F309	
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 F328 as it relates to oxygen use.	C 788	C 788 Refer to Federal POC F328	
C 789	02.200,03,b,v Prevention of Decubitus	C 789		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001120</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C <b>05/09/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>		
(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 789	Continued From page 3  v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for exercise to promote circulation; This Rule is not met as evidenced by: Please refer to F-314 as it relates to pressure ulcers.	C 789	C 789 Refer to Federal POC F314	
C 792	02.200,03,b,viii Comfortable Environment  viii. Maintenance of a comfortable environment free from soiled linens, beds or clothing, inappropriate application of restraints and any other factors which interfere with the proper care of the patients/residents; This Rule is not met as evidenced by: Please refer to F323 as it relates to physical restraints.	C 792	C 792 Refer to Federal POC F323	
C 807	02.200,04,g,iii Date and Time of Administration  iii. Date and time of administration; This Rule is not met as evidenced by: Please refer to F332 as it relates to times of medication administration.	C 807	C 807 Refer to Federal POC F 332	
C 879	02.203 PATIENT/RESIDENT RECORDS  203. PATIENT/RESIDENT RECORDS. The facility maintains medical records for all patients/residents in accordance with accepted professional standards and practices.	C 879	C 879 Refer to Federal POC F514	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001120</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/09/2014</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>
---	---

(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 879	Continued From page 4  This Rule is not met as evidenced by: Please refer to F514 as it relates to incomplete medical records.	C 879		



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

June 18, 2014

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

Provider #: 135015

Dear Ms. Henderson:

On **May 9, 2014**, a Complaint Investigation survey was conducted at Payette Center. Becky Thomas, R.N. and Amy Barkley, R.N. conducted the complaint investigation. The complaint was investigated in conjunction with the Recertification and State Licensure survey on May 5, 2014 to May 9, 2014.

The following documents were reviewed:

- The identified resident's closed record, along with the records of nine other sampled residents;
- Grievances from December 2013 to May 2014;
- Incident/Accident Reports from December 2013 to May 2014;
- Resident Council Meeting minutes from December 2013 to May 2014; and
- Staffing records from March 30, 2014 to April 5, 2014.

Four individual resident's interviews were conducted and a resident group interview was conducted, four residents were present.

Interviews were conducted with a variety of facility staff, including Certified Nurse Aides (CNAs) and a Registered Nurse (RN).

The complaint allegations, findings and conclusions are as follows:

Shelly Henderson, Administrator  
June 18, 2014  
Page 2 of 3

**Complaint #ID00006446**

ALLEGATION #1:

The complainant reported the identified resident used his or her call light to ask for assistance with the bedpan. The CNA entered the resident's room and told the resident he or she would be back in 5-10 minutes but did not return for an hour. The resident had a bowel movement in his clothes before the CNA returned.

FINDINGS:

The complaint covered the admission date of December 11, 2013 to April 9, 2014.

One of four residents present at the resident group interview stated, "There have been 'several' times when I put on my call light, the CNA comes in and turns it off and states he or she will be right back, and he or she doesn't come back. By the time the CNA or another CNA comes back, I have wet or soiled my pants." This resident stated he/she was embarrassed and upset.

The facility was cited at F241 as it relates to dignity.

CONCLUSIONS:

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

ALLEGATION #2:

The complainant reported the resident was sent to a local hospital, and upon admission to the hospital, the resident was observed to have dried feces in the ulcers on his bottom and up his backside.

FINDINGS:

Grievances did not contain any documented concerns related to residents not being cleaned after having a bowel movement.

The identified resident's closed record from the facility, the admission note, admission assessment, wound care notes and nurses notes from the receiving hospital were reviewed.

An admission and wound care note documented, "On arrival for assessment of skin, patient had had a large bowel movement and according to the admitting RN, the BM (bowel movement) occurred en route to the hospital.

Shelly Henderson, Administrator  
June 18, 2014  
Page 3 of 3

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,

A handwritten signature in black ink that reads "LORENE KAYSER". The letters are somewhat stylized and slanted.

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

LKK/dmj