



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR  
LICENSING & CERTIFICATION  
DEBBY RANSOM, R.N., R.H.I.T – Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
FAX: (208) 364-1888  
E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

February 9, 2017

James Hayes, Administrator  
Payette Center  
1019 Third Avenue South  
Payette, ID 83661-2832

Provider #: 135015

Dear Mr. Hayes:

On **January 27, 2017**, a 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 a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

James Hayes, Administrator  
February 9, 2017  
Page 2 of 4

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **February 17, 2017**. Failure to submit an acceptable PoC by **February 17, 2017**, may result in the imposition of penalties by **March 16, 2017**.

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

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and
- Include dates when corrective action will be completed in column (X5).

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

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **March 3, 2017 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **April 27, 2017**. A change in the seriousness of the deficiencies on **March 13, 2017**, may result in a change in the remedy.

James Hayes, Administrator  
February 9, 2017  
Page 3 of 4

The remedy, which will be recommended if substantial compliance has not been achieved by **April 27, 2017** includes the following:

Denial of payment for new admissions effective **April 27, 2017**. [42 CFR §488.417(a)]

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

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **July 26, 2017**, if substantial compliance is not achieved by that time.

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

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

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **April 27, 2017** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

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

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

James Hayes, Administrator  
February 9, 2017  
Page 4 of 4

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

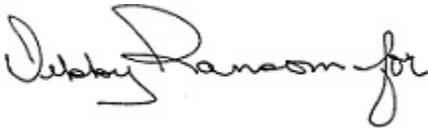
- BFS Letters (06/30/11)

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

This request must be received by **February 20, 2017**. If your request for informal dispute resolution is received after **February 20, 2017**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

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

Sincerely,

A handwritten signature in black ink, appearing to read "David Scott for". The signature is written in a cursive style with a large initial "D".

David Scott, RN, Supervisor  
Long Term Care

DS/lj

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

PRINTED: 03/03/2017  
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>01/27/2017</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	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the federal recertification and complaint survey conducted at the facility from January 23, 2017 January 27, 2017.</p> <p>The surveyors conducting the survey were:</p> <p>Teresa Kobza, RDN/LD, Team Coordinator Nina Sanderson, LSW Susan Costa, RN Edith Cecil, RN</p> <p>ABBREVIATIONS and DEFINITIONS:</p> <p>ADL = Activities of Daily Living CHO = Carbohydrate CNA = Certified Nursing Assistant DNS = Director of Nursing Services g or gm= gram LN = Licensed Nurse LPN = Licensed Practical Nurse MAR = Medication Administration Record MDS = Minimum Data Set mls = milliliter MSDS = Material Safety Data Sheet oz = ounce RD = Registered Dietician UTI = Urinary Tract Infection T = Tablespoon t = Teaspoon</p>	F 000			
F 162 SS=D	<p><b>483.10(f)(11)(i)-(iii) LIMITATION ON CHARGES TO PERSONAL FUNDS</b></p> <p>(f)(11) The facility must not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare (except for applicable</p>	F 162		3/3/17	

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

TITLE

(X6) DATE

Electronically Signed

02/17/2017

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: 03/03/2017  
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>01/27/2017</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 162	<p>Continued From page 1</p> <p>deductible and coinsurance amounts). The facility may charge the resident for requested services that are more expensive than or in excess of covered services in accordance with §489.32 of this chapter. (This does not affect the prohibition on facility charges for items and services for which Medicaid has paid. See §447.15 of this chapter, which limits participation in the Medicaid program to providers who accept, as payment in full, Medicaid payment plus any deductible, coinsurance, or copayment required by the plan to be paid by the individual.)</p> <p>(i) Services included in Medicare or Medicaid payment. During the course of a covered Medicare or Medicaid stay, facilities must not charge a resident for the following categories of items and services:</p> <p>(A) Nursing services as required at §483.35.</p> <p>(B) Food and Nutrition services as required at §483.60.</p> <p>(C) An activities program as required at §483.24(c).</p> <p>(D) Room/bed maintenance services.</p> <p>(E) Routine personal hygiene items and services as required to meet the needs of residents, including, but not limited to, hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton</p>	F 162			

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>01/27/2017</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 162	<p>Continued From page 2</p> <p>balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services, bathing assistance, and basic personal laundry.</p> <p>(F) Medically-related social services as required at §483.40(d).</p> <p>(G) Hospice services elected by the resident and paid for under the Medicare Hospice Benefit or paid for by Medicaid under a state plan.</p> <p>(ii) Items and services that may be charged to residents' funds. Paragraphs (f)(11)(ii)(A) through (L) of this section are general categories and examples of items and services that the facility may charge to residents' funds if they are requested by a resident, if they are not required to achieve the goals stated in the resident's care plan, if the facility informs the resident that there will be a charge, and if payment is not made by Medicare or Medicaid:</p> <p>(A) Telephone, including a cellular phone.</p> <p>(B) Television/radio, personal computer or other electronic device for personal use.</p> <p>(C) Personal comfort items, including smoking materials, notions and novelties, and confections.</p> <p>(D) Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare.</p> <p>(E) Personal clothing.</p>	F 162			

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>01/27/2017</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 162	Continued From page 3  (F) Personal reading matter.  (G) Gifts purchased on behalf of a resident.  (H) Flowers and plants.  (I) Cost to participate in social events and entertainment outside the scope of the activities program, provided under §483.24(c).  (J) Non-covered special care services such as privately hired nurses or aides.  (K) Private room, except when therapeutically required (for example, isolation for infection control).  (L) Except as provided in (e)(11)(ii)(L)(1) and (2) of this section, specially prepared or alternative food requested instead of the food and meals generally prepared by the facility, as required by §483.60.  (1) The facility may not charge for special foods and meals, including medically prescribed dietary supplements, ordered by the resident's physician, physician assistant, nurse practitioner, or clinical nurse specialist, as these are included per §483.60.  (2) In accordance with §483.60(c) through (f), when preparing foods and meals, a facility must take into consideration residents' needs and preferences and the overall cultural and religious make-up of the facility's population.  (iii) Requests for items and services.	F 162			

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>01/27/2017</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 162	<p>Continued From page 4</p> <p>(A) The facility can only charge a resident for any non-covered item or service if such item or service is specifically requested by the resident.</p> <p>(B) The facility must not require a resident to request any item or service as a condition of admission or continued stay.</p> <p>(C) The facility must inform, orally and in writing, the resident requesting an item or service for which a charge will be made that there will be a charge for the item or service and what the charge will be. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, it was determined the facility failed to ensure 1 random resident (Resident #12) was not charged for a medically prescribed dietary supplement. This deficient practice had the potential to compromise residents' nutritional health if they were unable to obtain the physician ordered nutritional supplement due to cost. Findings include:  Resident #12 was admitted to the facility on 2/5/15, with a diagnosis of muscle wasting and atrophy.  Physician orders for January 2017, documented a Tangy Tangerine 2.0 supplement was ordered for Resident #12 on 9/2/15. The physician order documented Resident #12 was to receive 2 scoops of the supplement daily mixed in liquid for her to sip on through out the day for vitamin/mineral supplement.</p>	F 162	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, River Ridge Care and Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.</p> <p>Affected On 02/13/2017 The Center Nurse Executive met with resident #12 related to her requests for supplements. The resident agreed to take supplements that the center would provide and that were available at the facility. The physician</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>01/27/2017</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 162	<p>Continued From page 5</p> <p>On 1/24/17 at 11:30 am, during observation of medication administration for Resident #12, LN #1 stated the Tangy Tangerine supplement was not available. LN #1 stated the supplement was used per Resident #12's request and LN #1 was not sure if Resident #12 had ordered it, if the facility was going to order it, or what was going on. A fax was then sent to Resident #12's physician requesting to hold Resident #12's Tangy Tangerine 2.0 until Resident #12 was able to obtain more as her current supply was exhausted and to restart at the current instruction when more product was obtained.</p> <p>On 1/25/17 at 12:12 pm, the facility received a fax from Resident #12's physician which documented "Above plan is approved", signed and dated 1/24/17. The word HOLD was written on the MAR for 1/25/17 through 1/27/17, and a single line through 1/28/17 through 1/31/17, indicating the Tangy Tangerine supplement would not be given.</p> <p>On 1/26/17 at 4:45 pm, Resident #12 stated she purchased the Tangy Tangerine supplement because, "my physician wanted me to have it." Resident #12 stated "I am trying to get it ordered right now but my credit card is not working." Resident #12 stated, "You don't know how it would help if I didn't have to pay for this, it is expensive."</p> <p>On 1/26/17 at 5:00 pm, the DNS stated she was aware Resident #12 was a Medicaid recipient and the supplement was ordered by the physician. The DNS stated there were over the counter multivitamins with minerals available to Resident #12, but she chose to take the Tangy</p>	F 162	<p>was contacted by the licensed nurse and agreed that the supplements would meet resident's needs, and a new order was obtained for supplement on 02/13/2017. Resident #12 was assessed by a licensed nurse on 01/30/2017 for any adverse effect associated with not receiving ordered supplements with none noted. Potential: On or before 02/17/2017, residents will be reviewed by the Director of Nursing or designee to ensure that all medications/ supplements ordered per MD are being provided by the center. Follow-up will be completed as indicated. Systemic: On or before 03/03/2017, the Executive Director will educate the Center Nurse Executive and Nursing Staff responsible for ordering medications and supplements on the Medicaid requirements for covering the costs of resident medications. Monitor: Beginning 03/03/2017 the Director of Nursing or designee will complete 3 r audits of Medicaid residents weekly times 4 weeks, and monthly for 2 months, of Medicaid residents to ensure all necessary medications ordered by the MD are purchased by the facility. The Director of Nursing will bring findings through QAPI monthly times 3 months or until compliance is achieved. Director of Nursing will monitor for compliance.</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>01/27/2017</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 162	Continued From page 6 Tangerine 2.0 supplement.	F 162			
F 241 SS=E	<p>483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>(a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure staff demonstrated respect for residents' dignity by offering choices of clothing protectors during meals and using age appropriate language when referring to clothing protectors. This was true for 1 of 11 sample residents (#2) and 3 random resident (#13, #14 and #19) observed dining. This had the potential to diminish residents' self-esteem and self-worth. Findings include:</p> <p>During the evening meal observation on 1/26/17 at 5:50 pm, CNA #1 was observed removing clothing protectors from a cabinet in the dining room. CNA #1 placed clothing protectors on Residents #2 and #19, who were seated at the table. She did not speak to either resident as she put them on. Residents #2 and #19 were not offered a choice of a cloth napkin or clothing protector.</p> <p>At 6:03 pm, during the observation, CNA #1 brought clothing protectors to Residents #13 and #14. She asked them "Do you ladies want a bib?" They were not referred to as clothing protectors, and they were not provided a choice of a cloth</p>	F 241	<p>Affected On 02/10/2017, the resident#2, # 13, #14, and #19 were assessed by the Licensed Social Worker for any psychosocial harm from the staff member referring to the clothing protector as a bib." On or before 03/03/2017 the Executive Director will review the use of clothing protectors versus cloth napkins with residents at resident council meeting. Follow-up will be completed based on resident choice. Potential On or before 03/03/2017, the Nurse Practice Educator or designee will audit residents for the use of a clothing protector. Follow-up will be immediately completed to include education for staff members that they are only to be referred to as clothing protectors in order to maintain the resident's dignity, and residents are to be offered choice between a cloth napkin or clothing protector as needed. Systemic On or before 03/03/2017, center staff will</p>	3/3/17	

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

PRINTED: 03/03/2017  
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>01/27/2017</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 241	Continued From page 7 napkin before the "bib" was offered.  On 1/16/17 at 7:00 pm, the DNS stated the staff should not have called clothing protectors "bibs", and should offer residents a choice before application.	F 241	be educated on dignity and resident rights by the Licensed Social Worker or designee.  Monitor Beginning 03/03/2017 each meal time will be audited 3x weekly for 4 weeks and monthly for 2 months to ensure that residents are being offered clothing protectors or napkins and that they are referred to in an appropriate manner. All findings will be brought through the QAPI meeting monthly or until substantial compliance is met. The Center nurse Executive will monitor for compliance.		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care.  483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.  (l) Dialysis. The facility must ensure that	F 309		3/3/17	

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>01/27/2017</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 8</p> <p>residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview, it was determined the facility failed to ensure residents received appropriate bowel care. This was true for 2 of 9 sampled residents (#3) reviewed for bowel care and/or pain management. These deficient practices placed residents at risk of severe discomfort, bowel impactions, and ongoing pain. Findings include:</p> <p>1. Resident #3 was admitted to the facility on 12/21/09 and readmitted to the facility on 1/26/11, with diagnoses including peripheral vascular disease, bipolar disorder, depression, and anxiety.</p> <p>Resident #3's physician orders for the month of January 2017 and December 2016, documented the following bowel care instructions:</p> <ul style="list-style-type: none"> <li>- Docusate Sodium 100 mg twice daily by mouth for constipation.</li> <li>- Milk of Magnesia, 30 mls by mouth PRN (as needed) for constipation. Give on day shift if no bowel movement for 2 days.</li> <li>- Dulcolax suppository rectally PRN for constipation. Give on evening shift if no bowel movement for 3 days.</li> <li>- Fleets enema 17-19 gms rectally PRN for constipation. Give if no results from suppository in 2 hours. Call MD if no results.</li> </ul>	F 309	<p>Affected:</p> <p>On 01/30/2017, Resident #3 was assessed by the Center Nurse Executive for adverse effects, finding multiple refusals of bowel care, with no pain or discomfort, or other adverse effect. Resident #3's bowel regimen was reviewed by the Center Nurse Executive on 01/30/2017 and the physician was updated. The Center Nurse Executive updated resident #3's plan of care to reflect the potential for constipation, including goals and interventions.</p> <p>On 01/30/2017, resident #7 was assessed by the Center Nurse Executive for effectiveness of her pain medication, with the resident stating the medication was effective.</p> <p>On or before 03/03/2017 a review of resident #7's current pain, assessment, medication regimen and plan of care will be completed by the Center Nurse Executive or designee to ensure that current interventions for pain management meet resident needs. Follow-up will be completed as indicated by the review.</p> <p>Potential:</p> <p>On or before 03/03/2017, residents will be audited by the Center Nurse Executive or designee, for timely completion of bowel</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>01/27/2017</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 9</p> <p>Resident #3's ADL Record for January 2017, documented she did not experience a bowel movement for four days from 12/31/16 to 1/3/17, five days from 1/5/17 to 1/9/17, four days from 1/12/17 to 1/15/17, and three days from 1/20/17 to 1/22/17. Resident #3 received all routine doses of Docusate Sodium for the month of January 2017. Resident #3 did not receive the PRN medications as ordered by the physician, for the episodes of constipation in the month of January 2017.</p> <p>Resident #3's ADL Record for December 2016, documented Resident #3 did not experience a bowel movement for four days from 12/6/16 to 12/9/16, three days from 12/11/16 to 12/13/16, and three days from 12/24/16 to 12/26/16. Resident #3 received all routine doses of Docusate Sodium in the month of December 2016. Resident #3 did not receive PRN medications, as ordered by the physician for the episodes of constipation in the month of December 2016.</p> <p>On 1/26/17 at 5:00 pm, the DNS stated Resident #3 "refused a lot."</p> <p>Resident #3's current Care Plan did not address constipation. Her record did not include documentation her physician was notified of her episodes of constipation and her reluctance to use the PRN medications ordered for her. There was no documentation Resident #3's current interventions for constipation were reviewed for efficacy, and if determined necessary, revised to reduce or eliminate her episodes of constipation.</p> <p>2. Resident #7 was admitted to the facility on</p>	F 309	<p>care, and proper documentation of PRN pain efficacy as per company policy.</p> <p>Systemic: On or before 03/03/2017, the Nurse Practice Educator or designee will educate nursing staff to ensure that they are following policy when giving bowel care and pain medications. Beginning 03/03/2017 the Center Nurse Executive will review a sample of residents' pain and bowel flow sheets at the center's IDT Customer at Risk Meeting to ensure that residents' are receiving bowel care and pain management as needed. Concerns identified in the IDT review will be addressed at that time.</p> <p>Monitor: Beginning 03/03/2017, the Center Nurse Executive or designee will monitor 3 residents to ensure that bowel movements and pain efficacy are being charted per policy: weekly for 4 weeks and monthly for 2 months. All findings will be reviewed in QAPI monthly or until substantial compliance is met. The Center Nurse Executive will monitor compliance.</p>		

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

PRINTED: 03/03/2017  
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>01/27/2017</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 10 3/24/16, with diagnoses which included metastatic cancer with bone metastasis, osteoporosis, headaches, and a left nephrectomy with a nephrostomy tube [drains urine from the kidney into a collecting bag outside the body].  Resident #7's MAR for April 2016, documented she could have Norco 5/325 mg every 6 hours as needed, and either 1 or 2 Tramadol HCl tablets every 6 hours, as needed, for pain.  Resident #7's MAR for April 2016, documented she received Norco on:  * 4/7/16 at 7:00 pm, for pain in her abdomen rating 6/10 on the pain scale * 4/8/16 at 12:30 pm, for an undocumented pain level and location * 4/9/16 at noon, for an undocumented pain level and location * 4/11/16 at 12:50 pm, for pain in her abdomen rating 4/10  The MAR did not document a reassessment of Resident #7's pain levels to determine the effectiveness of the Norco.  On 1/25/17 at 10:40 am, the DNS stated she could not determine, from looking at Resident #7's record, how the effectiveness of the pain medication had been evaluated.	F 309			
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER  (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain	F 315		3/3/17	

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>01/27/2017</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 315	<p>Continued From page 11</p> <p>continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.</p> <p>(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-</p> <p>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;</p> <p>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and</p> <p>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.</p> <p>(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure an assessment was completed in a timely manner for the continued use of a Foley urinary catheter and that catheter care was consistently</p>	F 315	<p>Affected: Resident #8 was discharged on 01/02/2017 Potential: On or before 03/03/2017, residents with</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>01/27/2017</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 315	<p>Continued From page 12</p> <p>performed for 1 of 3 residents (#8) reviewed for Foley catheter use. The failure created the potential for more than minimal harm if Resident #8 developed a UTI due to unnecessary catheter use. Findings include:</p> <p>Resident #8 was admitted to the facility 12/22/16 with diagnoses which included adenocarcinoma, DM, osteoporosis, and urinary retention.</p> <p>Resident #8's December 2016 Physicians' orders, dated 12/23/16 and initiated on 12/29/16, documented staff was to change the catheter site transparent dressing and document catheter measurements every day shift.</p> <p>Resident #8's January 2017 Physicians' orders documented:</p> <ul style="list-style-type: none"> <li>*Staff was to change the bedside Foley drainage bag when the bag became occluded, needed changed, or as needed, ordered 12/23/16.</li> <li>* Staff was to empty Foley Catheter drainage bag every shift and as needed, ordered 12/23/16.</li> <li>* Staff was to perform Foley Catheter care as needed, ordered 12/23/16.</li> <li>* Staff was to perform Foley Catheter care every evening and night shift, ordered 12/23/16.</li> </ul> <p>Resident #8's Physicians' orders did not document the reason for the catheter.</p> <p>Resident #8's 12/22/16 Initial Nursing Admission assessment, documented she had a Foley catheter.</p> <p>Resident #8's 12/22/16 through 1/4/17 progress notes, documented she had a Foley catheter.</p>	F 315	<p>urinary catheters will be assessed by the Center Nurse Executive or designee for appropriateness, and consistent documentation of catheter care, any identified concerns will be immediately addressed</p> <p>Systemic: On or before the 03/03/2017 the Nurse Practice Educator or designee will educate licensed nurses on the need to document the appropriateness of urinary catheter placement and the plan for discontinuation the time of admission, as well as insuring the order for daily urinary catheter care is in place. Beginning 03/03/2017 new residents will be reviewed in weekly IDT Customer at Risk (CAR) meeting for the first 4 weeks post admission by the Center Nurse Executive or designee, including a review of resident's with catheters to ensure adequate justification, or need for removal.</p> <p>Monitor: Beginning 03/03/2017, the Center Nurse Executive or designee will audit 3 residents with catheters each week for 4 weeks and monthly for 2 months to ensure all residents with Foleys have a justification and a note stating the MD plan for discontinuation. Center Nurse Executive will review all findings in QAPI monthly for 3 months or until substantial compliance has been met. The Center Nurse Executive will monitor for compliance.</p>		

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

PRINTED: 03/03/2017  
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>01/27/2017</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 315	<p>Continued From page 13</p> <p>Resident #8's Nurses' Note, dated 12/26/16, documented she had urinary retention and the facility would work on discontinuing the Foley catheter.</p> <p>Resident #8's clinical records did not contain documentation that the facility attempted to discontinue her Foley catheter.</p> <p>On 1/25/17 at 3:00 pm, the DNS stated Resident #8 was admitted from a local hospital with the catheter in place for urinary retention. The DNS stated she was waiting for Resident #8 to get stronger before attempting to the remove the Foley catheter. She stated the facility did not attempt to remove it while Resident #8 was in the facility. She stated the facility policy was to remove the Foley right away and if the removal failed to report it to the physician.</p> <p>Resident #8's December 2016 MAR, from 12/22/16 through 12/31/16, did not contain documentation that she received catheter care.</p> <p>Resident #8's January 2017 MAR, documented she received catheter care on 1/1/17 for two shifts.</p> <p>On 1/26/17 at 11:50 am, the DNS stated she could not find the documentation which showed the Foley catheter care was completed for December 2016. The DNS stated she talked with Resident #8 upon admit about the plan for the Foley catheter and the reasons for the continued use of the Foley. She stated Resident #8 did not want to get up and move, the facility was worried about skin issues, and Resident #8 was unable</p>	F 315			

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

PRINTED: 03/03/2017  
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>01/27/2017</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 315	Continued From page 14 to perform her ADL's without staff assistance. The DNS stated Resident #8's clinical records did not contain documentation of the conversation above with Resident #8.	F 315			
F 323 SS=E	<p>The facility did not ensure catheter care was completed in December 2016 and failed to ensure the facility attempted to remove the catheter consistent with facility policy.</p> <p>483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>(d) Accidents. The facility must ensure that -</p> <p>(1) The resident environment remains as free from accident hazards as is possible; and</p> <p>(2) Each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>(n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.</p> <p>(1) Assess the resident for risk of entrapment from bed rails prior to installation.</p> <p>(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.</p> <p>(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced</p>	F 323		3/3/17	

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>01/27/2017</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 15</p> <p>by: Based on observation and staff interviews, it was determined the facility failed to ensure toxic chemicals were secured. This was true for 1 of 10 sample residents (#6) and 2 random residents (#15 and #16). This failure also had the potential to negatively impact all other independently mobile residents who accessed the East Hall. Failure to secure toxic chemicals created the potential for residents to experience severe skin burns, serious eye damage, headache, GI symptoms, and irritation to the eyes, skin, mucus membranes and respiratory tract if they inhaled, ingested or were exposed to the toxic chemicals. Findings include:</p> <p>Unsecured chemicals were in areas accessible to residents as follows:</p> <p>a. On 1/25/17 at 10:42 am, the door to the Utility Closet in the East Hall, which contained hazardous material, was observed to be ajar. The surveyor was in the room for 10 minutes and observed multiple unsecured toxic chemicals in the room. The unsecured chemicals and their associated MSDS precautionary statements were:</p> <ul style="list-style-type: none"> <li>* PDI Sani-Cloth Plus Germicidal Disposable Cloth. - "Flammable Solids. Causes eye irritation...call a poison control center or doctor for treatment advice."</li> <li>* Clorox bleach Germicidal Wipes- "may cause eye irritation."</li> <li>* Quat Disinfectant Cleaner- liquid -"Eyes: mild irritation...including redness, pain and tearing, Inhalation: Respiratory tract irritation: Signs and symptoms may include cough, sneezing, nasal</li> </ul>	F 323	<p>Affected On 02/15/2017, the cited utility door closer was adjusted by the Maintenance Director and the door was secured.</p> <p>Potential On or before 03/03/2017, areas containing hazardous substances will be audited by the Maintenance Director to ensure door closers and lock knobs function correctly.</p> <p>Systemic On or before 03/03/2017, Staff will receive in-service from the Nurse Practice Educator or designee on hazardous material safety precautions, to include ensuring doors and or cupboards are properly secured.</p> <p>QAPI On or before 03/03/2017, audits of hazardous material storage areas will be audited by the Maintenance Director weekly for 4 weeks, and monthly for 4 months to verify these areas are properly secured.</p> <p>The results of the audits will be presented by the Maintenance Director in the monthly QAPI meeting. The Center Executive Director will monitor compliance.</p>		

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

PRINTED: 03/03/2017  
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>01/27/2017</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 16 discharge, headache, hoarseness, and nose and throat pain. Ingestion: Gastrointestinal irritation: signs and symptoms may include abdominal pain, stomach upset, nausea, vomiting, and diarrhea."  On 1/25/17 at 10:42 am, LPN #1, who was in the hallway by the East Nurses' Station, said the door to the hazardous materials room should "stay" closed and locked.  b. On 1/25/17, the Utility Closet in the East Hall, which contained hazardous material, was also observed to be ajar from 10:47 am to 10:59 am (12 minutes) with the unsecure chemicals as stated above.  On 1/25/17 at 10:59 am, the Staff Development Coordinator was in the hallway and observed the surveyor opening the door. The Staff Development Coordinator stated the Utility Closet door should be locked if chemicals were in the room. The Staff Development Coordinator stated she would get the door fixed as soon as possible; she entered the Utility room and saw the three chemicals above.  Resident's #6, #15 and #16 were observed in the hallway near the door when the Utility Closet was unsecured.	F 323			
F 364 SS=F	483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP  (d) Food and drink  Each resident receives and the facility provides-  (d)(1) Food prepared by methods that conserve	F 364		3/3/17	

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>01/27/2017</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 364	<p>Continued From page 17 nutritive value, flavor, and appearance;</p> <p>(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature; This REQUIREMENT is not met as evidenced by: Based on observation, menu review, and staff and resident interview, it was determined the facility failed to ensure meals served were flavorful and appealing for 9 of 9 (#1 - #6 and #9 - #11) sampled residents, and all other residents residing in the facility. Recipes were not followed resulting in foods being bland and unflavorful, and overcook or undercooked meats. This deficient practice created the potential for residents to experience unplanned weight loss, diminished nutritional health, and decreased sense of control of their environment. Findings include:</p> <p>a. The Resident Group interview was held on 1/24/17 at 10:00 am, with 11 residents in attendance. Eight residents expressed concerns with the food. Issues included unflavorful food items served, undercooked foods, dry and tough meats, and menu items not always being provided and available. Residents' comments included:</p> <p>* Two residents reported food ran out when they had asked for a specific food 2 weeks in advance, and they ended up having to eat tuna sandwiches. * One resident reported s/he wanted fewer carbohydrate options and more vegetables and fruits. * Four residents complained about the lack of variety on the menu and having to eat the same</p>	F 364	<p>Affected On 02/02/2017, the kitchen thermometers were re-calibrated by the Food Service Director. On 02/15/2017, the measuring spoons were replaced by the food service director. On 02/08/17, Kitchen staff received in-service regarding the importance of following the Genesis recipes. On 02/08/17, the Food Service Director received in-service regarding the importance of ensuring prior orders for upcoming meals were completed.</p> <p>Potential All residents had the potential to be effected by food quality.</p> <p>Systemic On or before 03/03/2017, the Food Service Director will provide additional oversight of food preparation, observing for conformance to recipes, food preparation, and cooking times. The Food Service Director will continue to meet monthly with the resident council to discuss food service and resident preferences. On or before 03/03/2017, the Food Service Supervisor and Registered Dietitian will provide in-service to the Kitchen Staff regarding conformance to recipes, food preparation and cooking</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>01/27/2017</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 364	<p>Continued From page 18</p> <p>thing over and over again. They stated they were always served chicken, broccoli and green beans. They stated you can only eat so much of one food item and not get sick and tired of it.</p> <ul style="list-style-type: none"> <li>* Three residents complained the food tasted bad and had no flavor to it.</li> <li>* One resident stated s/he was served foods s/he did not like over and over again even after telling the staff s/he did not like those foods.</li> </ul> <p>Residents stated the Dietary Manager was involved with the Resident Council Meetings and the issues sometimes got resolved. They stated they had brought up wanting tacos months ago and they still did not have tacos. They stated it was scheduled to be on the menu in a couple weeks.</p> <p>b. On 1/26/17, the dinner options for residents were as follows:</p> <ul style="list-style-type: none"> <li>* Crunchy Buttermilk Chicken</li> <li>* Garlic Mashed Potatoes</li> <li>* Sauteed Zucchini and Peppers</li> <li>* Warm Fruit Compote</li> <li>* Dinner Roll</li> <li>* Margarine</li> <li>* Parsley Garnish</li> </ul> <p>Alternate Meal options: If residents did not want the meal above the facility offered the following options for lunches and dinners every day. The options were as follows:</p> <ul style="list-style-type: none"> <li>* Soup and Sandwich</li> <li>* Hamburger/Cheeseburger</li> <li>* Cottage Cheese and Fruit Plate</li> </ul>	F 364	<p>times.</p> <p>QAPI On or before 03/03/2017, the Food Service Director or designee will audit one meal per day for three weeks, then 9 meals per month, to ensure the food is palatable, attractive, and at safe and appetizing temperatures. Beginning 03/03/17, the Food Service Director will report results of the meal audits in the Monthly QAPI meeting. The Food Service Director will be responsible for monitoring. The Food Service Director will continue to report food preference concerns &amp; comments of the Resident Council in the monthly QAPI meeting and follow-up on recommendations.</p>		

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

PRINTED: 03/03/2017  
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>01/27/2017</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 364	<p>Continued From page 19</p> <p>* Chef Salad</p> <p>The residents in the Resident Group interview stated they liked the other options, however, they stated the options got old fast.</p> <p>On 1/26/17 at 12:15 pm, the Dietary Manager was asked for a test tray and stated there was no food left and the kitchen had just made enough for the residents.</p> <p>On 1/26/17 at 3:00 pm, the kitchen staff was preparing the dinner meal. The first observation was the Sauteed Zucchini and Peppers. The cook stated she was making 40 servings which included 3 pureed and 3 chopped vegetables.</p> <p>The recipe instructions for Sauteed Zucchini and Peppers, for 40 servings, included:</p> <ul style="list-style-type: none"> <li>* Staff was to use 1 T plus 1 and 3/4 t of garlic powder.</li> <li>* Staff was to use 1 and 1/2 t of black pepper.</li> <li>* Staff was to use 3/4 t of salt.</li> <li>* Staff was instructed to preheat the convection oven to 425 degrees, bake the vegetables for 8-10 minutes, stir and turn over, and bake an additional 8-10 minutes or until the internal temperature was 145 degrees.</li> </ul> <p>The Cook #1 was using a 1/2 t measuring spoon when measuring out the garlic, pepper, and salt. Cook #1 used the 1/2 t three times for the garlic, to equal 1 and 1/2 t; one full 1/2 t for the pepper; and the 1/2 t filled up part way for the salt. When she was asked what measuring spoon she used, she showed the 1/2 t. Cook #1 asked if she measured it wrong, went over to the recipe and</p>	F 364			

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

PRINTED: 03/03/2017  
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>01/27/2017</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 364	<p>Continued From page 20 stated, "Oh I read that wrong I thought it said t not T." She started adding more spices, voiced confusion, and decided to dump the mixture out and started over.</p> <p>On 1/26/17 at 3:50 pm, Cook #1 started to prepare the Crunchy Buttermilk Chicken main dish.</p> <p>The recipe for the Crunchy Buttermilk Chicken for 40 servings, instructed staff to preheat the convection oven to 350 degrees, bake the chicken for 15 minutes or until the chicken reached an internal temperature of 165 degrees.</p> <p>Cook #1 dipped the chicken into the liquid component and then into the breading. After the chicken was coated she placed 6 coated chicken breasts and one plain breast on to the pan. She stated the plain one was for a resident who could not have milk. At 4:00 pm the pan was placed in the oven which was pre-heated to 375 degrees [recipe stated 350 degrees]. Cook #1 stated this tray was for all the pureed and mechanical soft diets. When Cook #1 was asked how long the chicken was to cook and she stated 18 minutes. Cook #1 prepared two additional pans of chicken and set them aside to be cooked later. The chicken was taken out of the oven at 4:32 pm, with an internal temperature of 180 degrees. The chicken appeared dry and wrinkled. The recipe called for the chicken to be cook for 15 minutes or until it reached an internal temperature of 165 degrees. This chicken was cooked for 32 minutes to an internal temperature of 180 degrees.</p> <p>While the chicken was in the oven, Cook #1 started to prepare the Warm Fruit Compote (40</p>	F 364		

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

PRINTED: 03/03/2017  
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>01/27/2017</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 364	<p>Continued From page 21 servings). The recipe called for orange juice 0.8 cups; lemon juice 3 T plus 1/2 t; granulated sugar 1 &amp; 1/2 cups, plus 1 T, plus 1 &amp; 3/4 t; ground cinnamon 1 T plus 1/4 t; and 1/2 t nutmeg.</p> <p>Cook #1 asked the Dietary Manager how she was to measure out 0.8 cups of orange juice. The Dietary Manager stated it was 2 T. Cook #1 used a T measuring spoon to measure out two T of orange juice.</p> <p>On 1/26/17 at 5:00 pm, the Dietary Manager placed the additional pans of chicken into the convection oven where two pans of Zucchini and Peppers had been cooking for 15 minutes. The oven temperature was set to 375 degrees.</p> <p>On 1/26/17 at 5:10 pm, the Dietary Manager started to prepare the Garlic Mashed Potatoes (40 Servings). The recipe instructions for Garlic Mashed Potatoes, for 40 servings, included:</p> <ul style="list-style-type: none"> <li>* 2 and 1/3 oz of garlic cloves.</li> <li>* 1 and 1/4 t of white pepper.</li> </ul> <p>The Dietary Manager used 1 and 1/4 t of garlic powder and 1/4 t of black pepper. She stated the kitchen did not have garlic cloves to use in the recipe which is why she used the garlic powder. One and 1/4 t of white pepper was not used.</p> <p>On 1/26/17 at 5:17 pm, Cook #1 took the pans of Zucchini and Peppers out of the oven and used a thermometer to test their temperature. The temperature read 72.7 degrees. Cook #1 grabbed a new thermometer to test the vegetables and it read 120 degrees. She asked the Dietary Manager for a different thermometer</p>	F 364			

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

PRINTED: 03/03/2017  
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>01/27/2017</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 364	<p>Continued From page 22 and the Dietary Manager got one from her office. Cook #1 tested the temperature again and it read 145 degrees. With the different temperature readings it could not be determined if the food reached the appropriate temperature.</p> <p>c. On 1/26/17 at 6:19 pm, a test tray was tried with RD #2 and the Regional RN present. The meal consisted of:</p> <ul style="list-style-type: none"> <li>* Crunchy Buttermilk Chicken - The chicken lacked flavor.</li> <li>* Sauteed Zucchini and Peppers - This was flavorful.</li> <li>* Garlic Mashed Potatoes - The garlic and other spices could not be tasted. In addition, the potatoes were lumpy and runny.</li> <li>* Fruit Compote - This was flavorful.</li> </ul> <p>On 1/26/17 at 6:19 pm, RD #2 tasted the food above. RD #2 stated the facility did test tray audits to monitor the food products produced by the kitchen. She stated the facility did other audits to watch for cross-contamination and sanitation issues, as well. RD #2 stated she would look into the concern with the thermometers giving different readings.</p> <p>d. On 1/26/17 at 6:10 pm, five random residents were observed consuming the dinner meal and asked staff for butter, salt and pepper to put on their potatoes because the residents said they lacked flavor.</p> <p>Residents #1-#6 and #9-#11, consumed food prepared in the kitchen. The facility failed to ensure recipes were followed by staff. Failure to follow the recipes changed the nutrient contents</p>	F 364			

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>01/27/2017</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 364	Continued From page 23 of the menus and affected the flavor of the food. This placed residents at greater risk of weight loss concerns if they lost appetites or did not want to eat the meals provided.	F 364			
F 366 SS=F	483.60(d)(4)-(6) SUBSTITUTES OF SIMILAR NUTRITIVE VALUE  (d)(4) Food that accommodates resident allergies, intolerances, and preferences;  (d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; and  (d)(6) Drinks, including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident hydration. This REQUIREMENT is not met as evidenced by: Based on observation, Resident Group interview, menu review, and staff interview, it was determined the facility failed to offer a nutritionally comparable alternate meal to residents. This was true for 8 of 11 residents in the Resident Group, 9 of 9 (#1 - #6 and #9 - #11) sampled residents and all other residents in the facility should they not wish to eat the main meal offered. The deficient practice had the potential for harm if residents experienced hunger and/or weight loss from not having complete meals served. Findings include:  The Resident Group interview was held on 1/24/17 at 10:00 am, with 11 residents in attendance. Eight residents expressed concerns with the food. Residents' comments included:  * Two residents reported food ran out when they	F 366	Affected On or before 03/03/2017, the Food Services Director will interview residents #1-#6 and #9-#11 to determine their preferences for the always available menu offerings. Potential On or before 03/03/2017, the Food Services Director will interview residents not identified to determine their preferences for the always available menu offerings. On or before 03/03/2017 the Food Service Director will consult with the Registered Dietitian to develop additional recipes for the always available menu based upon the resident preferences. The Registered Dietitian will ensure the	3/3/17	

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>01/27/2017</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 366	<p>Continued From page 24</p> <p>had asked for a specific food 2 weeks in advance, and they ended up having to eat tuna sandwiches.</p> <p>* Four resident complained with the lack of variety on the menu and having to eat the same thing over and over again. They stated they were always served chicken, broccoli and green beans. They stated you can only eat so much of one food item and not get sick and tired of it.</p> <p>* One resident stated s/he was served foods s/he did not like over and over again even after telling the staff s/he did not like those foods.</p> <p>On 1/26/17, the dinner option for residents were as follows:</p> <p>* Crunchy Buttermilk Chicken - This provided 233 calories, 0.4 g of fiber, 8.6 g of CHO, and 24.7 g of protein.</p> <p>* Garlic Mashed Potatoes - Nutrient analysis was not provided.</p> <p>* Sauteed Zucchini and Peppers - This provided 63 calories, 1.6 g of fiber, 5.1 g of CHO, and 1.6 g of protein.</p> <p>* Warm Fruit Compote - This provided 126 calories, 2.3 g of fiber, 32.2 g of CHO, and 0.3 g of protein.</p> <p>* Dinner Roll - Nutrient analysis was not provided.</p> <p>* Margarine</p> <p>* Parsley Garnish</p>	F 366	<p>recipes contain the proper nutritional values.</p> <p>On or before 03/03/2017, the Registered Dietitian will conduct a nutritional analysis of the current always available menu offerings to determine nutritional value, and recommend recipe adjustments which may be necessary. The food service Director will ensure adherence to the posted recipes.</p> <p>Systemic</p> <p>Beginning 03/03/2017, the Always available menu items will be prominently posted in the Dining room so as to be available to residents.</p> <p>Beginning 03/03/2017, the Food Service Director will alternate the always available offerings each week.</p> <p>QAPI</p> <p>Beginning 03/03/2017, the Food Service director will monitor the portion control and ingredients for the always available offerings served to ensure they comply with the previously approved recipes; 3 times per week for 4 weeks and 1 time per week for 3 months. The Administrator will monitor compliance.</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>01/27/2017</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 366	<p>Continued From page 25</p> <p>Alternate Meal option: * An alternate meal was not prepared for the residents.</p> <p>The Dietary Manager, RD #1, and RD #2 stated they did not serve a specific alternate meal option to residents. They said instead they provided "always available" options to residents. The "always available" options residents could choose from were as follows:</p> <p>Breakfast "always available" options included:</p> <p>* Eggs with toast and jelly - The nutrient analysis for this option was not provided for review.</p> <p>* Cottage cheese and fruit plate with a breakfast muffin - The cottage cheese and fruit plate provided 240 calories, 4.1 g of fiber, 44.8 g of CHO and 13 g of protein. This meal lacked sufficient calories, fiber, and protein.</p> <p>* Fruit and yogurt parfait with a breakfast muffin - The nutrient analysis for this option was not provided for review.</p> <p>* Waffles with warm syrup - The waffle provided 209 calories, 0 g of fiber, 27.6 g of CHO, 5 g of protein, and 8.5 g of fat. This option lacked sufficient calories, protein, and fiber. In addition, it was higher in fat at 37.1 percent of calories coming from fat.</p> <p>Lunch and Dinner "always available" options included:</p> <p>* Soup and Sandwich of the day - The nutrient analysis for the soup was not provided for review.</p>	F 366			

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>01/27/2017</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 366	<p>Continued From page 26</p> <p>A turkey sandwich provided 205 calories, 2.6 g of fiber, 28.4 g of CHO, and 17.1 g of protein. This option could not be assessed fully without the soup component. (The sandwich was made with wheat bread.)</p> <p>* Hamburger/cheeseburger with lettuce, tomatoes, pickles, onions, ketchup, mustard and a side item - The Hamburger/cheeseburger provided 383/388 calories, 1.3/1 g of fiber, 27.8/26.7 g of CHO, and 21.4/21 g of protein. This option lacked sufficient fiber and carbohydrates. (The bun used was made with white bread.)</p> <p>* Cottage cheese and fruit plate with a breakfast muffin - The cottage cheese and fruit plate provided 240 calories, 4.1 g of fiber, 44.8 g of CHO and 13 g of protein. This meal lacked sufficient calories, fiber, and protein.</p> <p>* Chef salad made with iceberg lettuce, deli meat, shredded cheese, hard cooked eggs, fresh vegetables, and dressing - The chef salad provided 155 calories, 1.1 g of fiber, 5.3 g of CHO, 14.9 g of protein. This meal lacked sufficient calories, fiber, carbohydrates, and protein.</p> <p>On 1/26/17 at 3:30 pm, RD #2 stated the facility did not have a system to ensure the "always available" option had equivalent nutrient values. She stated if a resident wanted a chef salad the facility would provide a dinner roll upon request. She stated a side of vegetables could be provided with all of the options if a resident requested them. In addition, she stated she did not believe the facility had to provide an alternate</p>	F 366			

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>01/27/2017</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 366	Continued From page 27 meal because of the size of the facility.	F 366			
F 371 SS=F	<p>Residents #1 - #6 and #9 - #11, consumed food prepared in the kitchen. The "always available" options lacked variety, vegetables, fruits, whole grains, and sufficient carbohydrates/fiber/and protein options. Nutritionally similar meal alternatives were not available for residents. The facility failed to ensure nutritional adequate alternatives were provided to residents.</p> <p>483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.</p> <p>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.</p> <p>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.</p> <p>(iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.</p> <p>(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption.</p>	F 371		3/3/17	

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>01/27/2017</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 371	<p>Continued From page 28</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure measures were in place to prevent possible cross-contamination a) of dirty to clean areas in the kitchen; b) during food preparation and service; and c) of foods stored in the freezer. This was true for 9 of 9 (#1 - #6 and #9 - #11) sampled residents and all other residents residing in the facility. This had the potential for harm if residents contracted foodborne illnesses or contagious diseases. Findings include:</p> <p>1. Kitchen Tours:</p> <p>a. Initial Tour of the kitchen: On 1/23/17 at 9:30 am, the overall appearance of the kitchen was observed with worn spots on the floor, missing and broken tiles in the freezer, and 3 inch by approximately 1/2 inch thick ice crystals covering the majority of the freezer ceiling.</p> <p>b. Second Tour of the Kitchen:</p> <p>On 1/23/17 at 2:15 pm, the freezer was observed again. The storage of the meat in the freezer was as follows:</p> <ul style="list-style-type: none"> <li>* Top Shelf: Raw breaded fish patties in an open box with the bag open to the elements.</li> <li>* Next Shelf: Raw chicken breasts in bags.</li> <li>* Next shelf: Pre-cooked chicken patties in an open box.</li> <li>* Bottom Shelf: Beef roast next to a raw turkey product.</li> </ul> <p>On another shelving unit, raw ground pork was</p>	F 371	<p>On 01/23/2017, Food items in the freezer were repositioned to ensure proper organization on the shelf units. Out of date food was discarded.</p> <p>On 02/17/2017, the identified employees were counseled and received in-service regarding sanitation and food handling procedures.</p> <p>Potential On or before 03/03/2017 the Center Executive Director will purchase a new reach-in freezer, which will be located in the kitchen storage area.</p> <p>On or before 03/03/2017, the Food Service Director will audit the food inventory to ensure proper organization of frozen food items, and proper preparation of food items for freezer storage.</p> <p>On or before 03/03/2017, Kitchen staff will receive in-service on dating food items, infection control, handwashing, and adherence to facility policies regarding dishwashing and food handling procedures.</p> <p>Systemic On or before 02/15/2017, the Food Service Director will conduct the weekly food service and sanitation audit. She will report findings weekly in the Stand-up meeting.</p> <p>QAPI On or before 03/03/15, the Food Service Director will conduct the weekly food service and sanitation audit 3 times a week for 2 weeks, then weekly as per policy. Results of these audits will be</p>		

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

PRINTED: 03/03/2017  
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>01/27/2017</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 371	<p>Continued From page 29</p> <p>stored next to and above pre-cooked food items.</p> <p>The Dietary Manager, present during the tour, stated the way the food was currently stored was incorrect and she would correct it. During this observation in the freezer the ice crystals on the ceiling were dripping water various places in the freezer. There was an icy spot on the freezer floor and the Dietary Manager could not ensure the ice crystals on the ceiling had not dripped onto the food items.</p> <p>During the tour the freezer was found to have multiple items with no date marking of any kind. The foods without dates included pork loins and 8 containers of whipped cream. In addition, the freezer contained multiple products that had use by dates that had past or the product was open and exposed to the elements in the freezer. These products included:</p> <ul style="list-style-type: none"> <li>* Canned refried beans in a bag with a use by date of 10/9. (The bag did not have a year on it.)</li> <li>* Canned apples in a bag with a use by day of 10/22. (The bag did not have a year on it.)</li> <li>* Two bags of enchiladas with a use by date of 10/24. (The bag did not have a year on it.)</li> <li>* Two bags of chicken noodle soup with a use by date of 11/19. (The bag did not have a year on it.)</li> <li>* An open bag of rice with no date on it. The rice had ice crystals throughout the product.</li> <li>* A torn bag of pulled pork with the meat touching the freezer's shelf.</li> <li>* Canned pumpkin in an unsealed bag which contained ice crystal.</li> </ul> <p>The beans, apples, enchiladas, and chicken noodle soups were located in a bin together. The</p>	F 371	<p>reported in Stand-up meeting, and in the monthly QAPI meeting. The Center Executive Director will monitor compliance.</p>		

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

PRINTED: 03/03/2017  
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>01/27/2017</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 371	<p>Continued From page 30</p> <p>bottom of the bin had a gelatinous congealed fat-like substance covering 1/4 of it. The bags listed above were in that substance.</p> <p>The Dietary Manager stated the products should be removed when they were older than 45 days; and without date marking it would be difficult to determine how long a product had been in the freezer. In addition, she stated the cleanliness of the freezer should be better than observed. She stated she would remove the expired and ruined products and clean the soiled bin.</p> <p>2. Dishware Washing:</p> <p>a. On 1/23/17 at 9:30 am, Cook #2 was observed during the dishwashing process. She had two gloves on each hand. The glove on top was her dirty glove and the one underneath was the clean glove. Cook #2 wore her apron on both the dirty and clean sides of the dish washing process. When she went over to the clean dish side, some dishes fell against her body and touched her apron. The same dishes continued to be put away for future use.</p> <p>Cook #2 stated she usually flipped her apron up around her neck when she was on the dirty side and flipped her apron down around her waist when she was on the clean side.</p> <p>The Dietary Manager, present during the observation, stated this was not the correct procedure for cleaning dishware.</p> <p>b. On 1/24/17 at 9:23 am, Cook #1 was observed during the dishwashing process. She was cleaning food particles off of dirty trays in the</p>	F 371			

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

PRINTED: 03/03/2017  
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>01/27/2017</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 371	<p>Continued From page 31</p> <p>hallway. She had her apron on and it hung down around her waist, not around her neck. As food particles were scraped off the plates and fluids poured into a container, particles were observed splashing on to the front of Cook #1's outfit. The front of her outfit was also observed touching the dirty trays when they were lifted out of the carts. At 9:31 am, Cook #1 flipped her apron up around her neck, placed two gloves on her hands, and started to wash the dirty dishes. After a load of dirty dishes finished its cycle, Cook #1 removed her dirty top glove. She then used that hand to turn the water off with her clean glove, by removing the ring from the water sprayer on the dirty side. Cook #1 then pulled the clean dishes from the dishwasher and pushed them through to the clean side. She placed her dirty glove back on, turned the water on, and continued to wash dishes. Cook #1 repeated this process twice. Cook #1 was asked which hand she had used to turn the water off and she stated she had used her clean hand. Cook #1 said she realized the error after the third time she did it. Cook #1 did not resanitize the dishware. After she finished Cook #1 took off her apron and went to the clean side. She washed her hands and started to put dishes away. When asked if the front of her shirt was contaminated, Cook #1 said did not know. When asked where her apron was in the hallway, she stated around her waist. She stated, "I did it again?"</p> <p>On 1/24/17 at 9:45 am, a Dietary Manager from a different facility stated clean dishware was not to touch staffs' bodies. The correct practice was to hold the dishware away from the body. The Dietary Manager from the other facility stated a cook's shirt would be considered contaminated if</p>	F 371			

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

PRINTED: 03/03/2017  
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>01/27/2017</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 371	<p>Continued From page 32 the cook was not wearing an apron and food splashed on to it.</p> <p>3. Food Preparation and Service:</p> <p>On 1/26/17 at 3:00 pm, the dinner meal preparation began. The foods prepared were:</p> <ul style="list-style-type: none"> <li>* Crunchy Buttermilk Chicken</li> <li>* Garlic Mashed Potatoes</li> <li>* Sauteed Zucchini and Peppers</li> <li>* Warm Fruit Compote</li> <li>* Dinner Roll</li> <li>* Margarine</li> <li>* Parsley Garnish</li> </ul> <p>On 1/26/17 at 3:38 pm, Cook #1 left the kitchen to go to the freezer, which was outside in another building, to get more supplies. She returned to the kitchen at 3:41 pm, with chicken and milkshakes. She did not wash her hands after dropping off the food items. She placed gloves on her hands and started putting handfuls of chicken into a pan. At 3:45 pm, she left the kitchen to go to the freezer again and returned at 3:48 pm. She washed her hands when she returned.</p> <p>On 1/26/17 at 3:50 pm, Cook #1 started to prepare the Crunchy Buttermilk Chicken main dish.</p> <p>She had no apron on while she prepared the raw chicken, dipped the chicken into the liquid component, and then into the breading. After she finished this task she placed the chicken in the oven.</p> <p>On 1/26/17 at 4:34 pm, Cook #1 started to</p>	F 371		

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

PRINTED: 03/03/2017  
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>01/27/2017</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 371	<p>Continued From page 33</p> <p>prepare the pureed food items. The cook followed the recipes for the pureed food items. When she finished pureeing the first item she took the blender over to a three compartment sink and washed the blender. Cook #1 was not wearing an apron and while she cleaned the blender she leaned over the sink and her outfit was touching the sink edge and water could be seen splashing onto her shirt. Cook #1 repeated this process after each food item was pureed. Cook #1 did not take precautions to prevent contamination between food preparation and sanitation of equipment.</p> <p>On 1/26/17 at 5:00 pm - 6:07 pm, Dietary Aide #1 entered the kitchen and started to prepare beverages for the residents. The aide did not wash his hands upon entering the kitchen. In addition, Dietary Aide #1 performed other tasks in the kitchen throughout the hour observation. The tasks included making coffee, preparing thickened liquids, pouring drinks, placing the Warm Fruit Compote, beverages, and lids onto the plates and trays at tray line. Throughout the observation Dietary Aide #1 was observed multiple times leaving and entering the kitchen, touching the trash can lid without washing his hands, then returning to his tasks. He was observed washing his hands twice throughout the observation.</p> <p>On 1/26/17 at 5:00 pm, the facility's Dietary Manager placed the additional pans of chicken into the convection oven where two pans of Zucchini and Peppers had been cooking for 15 minutes. The order of the pans in the oven were as follows, from top to bottom, chicken, zucchini, chicken, and zucchini.</p>	F 371			

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

PRINTED: 03/03/2017  
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>01/27/2017</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 371	<p>Continued From page 34</p> <p>On 1/26/17 at 5:17 pm, Cook #1 took the pans of Zucchini and Peppers out of the oven and used a thermometer to test the temperatures. The temperature read 72.7 degrees. Cook #1 grabbed a new thermometer to test the vegetables and it read 120 degrees. Cook #1 asked the Dietary Manager for a different thermometer and the Dietary Manager got one from her office. Cook #1 tested the temperature again and it read 145 degrees.</p> <p>Given the three different readings, it could not be determined if the food reached the appropriate temperature as required for food safety and per the recipe [145 degrees].</p> <p>On 1/26/17 at 5:59 pm, the cook started to dish up trays at tray line. The front of her shirt was observed touching plates and the pan which held dinner rolls in it. She leaned over the pan of rolls each time she removed one from the pan. The front of Cook #1's shirt throughout the night had touched multiple surfaces with no barrier worn.</p> <p>On 1/24/17 at 9:45 am, a Dietary Manager from a different facility, stated that to prevent cross-contamination from food preparation and sanitation of equipment, staff who are cooking will only be assigned to that task and would not do dishwashing.</p> <p>The facility failed to ensure sanitary practices were followed with food preparation, food storage, sanitation of dishware, and food service. The freezer floor and ceiling were not cleanable surfaces with the cracked floor and stalactites on the ceiling. These failed practices placed</p>	F 371			

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

PRINTED: 03/03/2017  
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>01/27/2017</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 371	Continued From page 35 residents at greater risk for acquiring foodborne illnesses and infections.	F 371			
F 431 SS=E	<p>483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--</p> <p>(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and</p> <p>(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>(g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p>	F 431		3/3/17	

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>01/27/2017</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 431	<p>Continued From page 36</p> <p>(h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure an expired glucometer glucose control test solution was removed from the medication refrigerator and multi-dose/multi-use medications were initialed and dated when opened for 1of 2 medication refrigerators checked. This failed practice created the potential for residents to receive medications with decreased efficacy and erroneous glucometer readings. Findings included:  On 1/26/17 at 10:20 am, the medication rooms on the 100 and 200 Halls were inspected with the Staff Development Coordinator [SDC]. The following was found in the 100 Hall medication room refrigerator:  * One multi-dose vial of influenza vaccine was not dated and initialed when opened.</p>	F 431	<p>Affected: On 01/26/2017, the flu vaccine and control solution were removed and disposed of by the Nurse Practice Educator. On, 01/26/2017, the multiuse bottle of Lorazepam was labeled and dated by the Licensed Nurse who opened the medication. On 01/26/2017, the undated control solution was disposed of and a new control solution was ordered by the Nurse Practice Educator.</p> <p>Potential: On or before 02/17/2017, the Center Nurse Executive or designee will audit the med rooms, medication carts, and treatment cart for expired and</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>01/27/2017</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 431	Continued From page 37 * One multi-use bottle of a Lorazepam was not dated and initialed when opened. * One box of glucometer glucose control solution had an expiration date of 12/2016  The SDC disposed of the influenza vaccine vial, ensured the Lorazepam had the appropriate date opened and initialed by the LN who had opened the bottle the day prior, and disposed of the glucometer glucose control solution.	F 431	undated/initialed medications. Any issues found will be corrected. Systemic: On or before 03/03/2017, the Nurse Practice Educator or designee will educate licensed nurses regarding the need to insure expired medications are removed and destroyed. Beginning on or before 03/03/2017 the night shift will complete a weekly inspection of the medication room for mislabeled or outdated medications. QAPI: Beginning 03/03/2017, the Center Nurse Executive or designee will audit medication rooms and carts: weekly for 4 weeks, and monthly times 2 months, to insure no expired medications are present, and that open vials are signed and dated. The Center Nurse Executive will report findings and corrective actions in the monthly QAPI meeting. The Center Nurse Executive will monitor compliance.		
F 441 SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS  (a) Infection prevention and control program.  The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:  (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment	F 441		3/3/17	

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

PRINTED: 03/03/2017  
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>01/27/2017</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 441	<p>Continued From page 38</p> <p>conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);</p> <p>(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed</p>	F 441			

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>01/27/2017</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 441	<p>Continued From page 39 by staff involved in direct resident contact.</p> <p>(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure staff performed standard hand hygiene measures to reduce the risk for infection. This was true for 6 of 19 residents (#2, #9, #14, #16, #18 and #19) observed dining. This failure created the potential for residents to develop infection from cross-contamination. Findings include:  During an evening meal observation on 1/26/17, beginning at 5:50 pm, CNA #1 was observed as she assisted residents before their meal arrived. CNA #1's left arm was in a sling and she performed tasks with her right. Hand hygiene was not performed during the following tasks:  * At 5:50 pm, CNA #1 put her right hand on the side of Resident #18's chair, and asked her what she wanted to drink. CNA #1 was observed as she took an apron down from a hook on the wall, fastened the apron, then prepared the beverage and delivered it to Resident #18. CNA #1 brought a cup of coffee to Resident #14, then turned to</p>	F 441	<p>Affected: On 01/26/2017, CNA #1 was counseled and received in-service education by the Center Nurse Executive regarding the facility hand washing policy. On 01/26/2017, Residents #2, #9, #14, #16, #18, and #19 were assessed by the Center Nurse Executive for signs and symptoms of infection, with none noted. Potential: On or before 02/17/2017 a center infection control and hand washing round was completed by the Nurse Practice Educator to ensure adequate hand washing and infection control practices. Any identified issues were immediately addressed. Systemic: On or before 03/30/2017, staff members will be educated and complete a hand washing competency administered by the Nurse Practice Educator or designee to ensure that regular hand washing was</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>01/27/2017</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 441	Continued From page 40 pick up a spoon out of a box that was on a cart. She gave the spoon to Resident #14.  * At 5:55 pm, CNA #1 was observed as she rubbed her eyes. She then removed folded clothing protectors from a cabinet. The clothing protectors were placed on Residents #2 and #19. CNA #1 touched Resident #9's arm, and after speaking to him, took his beverage cup to be refilled and returned the cup to him.  * At 5:58 pm, Resident #16 requested that his beverage be changed from the red juice to the orange colored juice. CNA #1 took Resident #16's beverage cup and changed his drink as he requested. After she brought the cup to Resident #16, she was observed as she went to the sink and washed her hands.  CNA #1 had direct contact with at least 6 residents, clean clothing protectors, beverage containers, and a box of plastic utensils without performing hand hygiene.  On 1/26/17 at 7:00 pm, the DNS stated staff should perform hand hygiene between residents when providing assistance at meals.	F 441	being completed per facility policy, and that clothing protectors are referred to as such in order to ensure resident dignity. On or before 03/03/2017 the Dining Room Manager Task List will be amended to include the additional focus of attention on staff infection control during each meal. The completed task list will be routed to the Center Nurse Executive daily with any negative observations noted. Monitor: Beginning 03/03/2017 the Center Nurse Executive or designee will audit 3 meals weekly for 4 weeks and monthly times 2 months to ensure hand washing completed per policy. She will bring findings through QAPI for 3 months or until substantial compliance is met. The Center Nurse Executive will monitor compliance.		
F 463 SS=E	483.90(f)(2) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH  (f) Resident Call System  The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area -	F 463		3/3/17	

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>01/27/2017</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 463	<p>Continued From page 41</p> <p>(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure a reliable communication system from residents' rooms, toilets, and shower room, to the nursing station was available. This was true for 1 of 3 (#3) shower rooms and 4 of 14 (#106, #120, #216, and #301) rooms checked for call lights. This failure created the potential for harm if residents or staff assisting residents could not alert others for assistance when needed. Findings include:</p> <p>a. On 1/23/17 at 10:40 am, a call light was sounding in the facility. None of the lights above residents' doors and at the nurses' station, lit up. The Business Office Manager and a CNA were going room to room to see who had requested assistance. The Business Office Manager found the resident who requested help was in room #106. This was corrected when the call light was adjusted by the Administrator.</p> <p>b. On 1/26/17 at 10:16 am, the following call lights were observed not to sound outside of the rooms or at the nurses' station when the Acting Maintenance Supervisor activated the call cord or the residents activated the call lights:</p> <p>* Shower Room #3 in the East Hall did not sound when activated and did not light up a different color to show an emergent call. *Rooms #120, #216 and #301 did not sound when activated.</p> <p>Call lights in the rooms were unplugged and plugged in multiple times. The call lights outside</p>	F 463	<p>Affected On 01/26/2017, the call lights in rooms 106, 120, 216, and 301 were examined and repaired by the Maintenance Director. Potential On or before 03/03/2017, call lights not mentioned in the 2567 will be examined by the Maintenance Director and repaired as necessary. Systemic On or before 03/03/2017, Staff will be educated by the Nurse Practice Educator to notify the Maintenance Director in the event a call light becomes inoperable. QAPI Beginning 03/03/2017, the Maintenance Director will inspect call lights for proper functioning weekly for four weeks and monthly for 3 months. Any issues found will be corrected immediately. He will bring the results of these inspections to the Monthly QAPI meeting to report findings and action taken. The Center Executive Director will monitor for compliance.</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>01/27/2017</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 463	Continued From page 42 the residents' rooms lit up, but no audible sound was heard. A staff member would have to be present in the hall to be made aware a resident needed assistance. The Acting Maintenance Supervisor replaced the plugs in the rooms above, and they were then functional.  The facility's Call Station Weekly Test Log was reviewed. Weekly tests were not documented from 1/1/17 to 1/26/17, at which time the call lights were tested as part of the survey process.  On 1/26/17 at 1:00 pm, the Administrator said he was not aware the log had not been completed and stated the regular Maintenance Supervisor was off. He stated he had various other individuals performing his tasks while he was away. The Administrator stated he would have all the call lights checked for functionality.	F 463			
F 468 SS=D	483.90(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS  (h)(3) Equip corridors with firmly secured handrails on each side; and This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure that handrails were securely fastened to walls. This had the potential to affect 2 of 9 (#4 & #10) sampled residents residing in the facility and all other ambulatory resident moving about the south and west hallways. The failure had the potential for more than minimal harm if residents sustained falls and/or injuries related to unsecured handrails. Findings include:  On 1/25/17 at 10:00 am, loose handrails were	F 468	Affected: On or 02/13/2017 the identified handrails were repaired by the Maintenance Director. Potential: On or before 03/03/2017 the remaining handrails will be audited by the Director of Maintenance. Unsecured rails will be repaired as needed by the Director of Maintenance. Systemic: On or before 03/03/2017 the Maintenance	3/3/17	

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

PRINTED: 03/03/2017  
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>01/27/2017</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 468	Continued From page 43 observed in South and West hallways, outside of Rooms #119 and #201. Resident #4 and Resident #10 moved about the two hallways.  On 1/26/17 at 10:16, during the environmental tour the Acting Maintenance Director was shown the loose handrails. The Acting Maintenance Director stated he could see that the handrails were loose and unattached from the handrail brackets.	F 468	Director will continue the current handrail inspection audit. Issues found will be corrected by the Maintenance Director in timely manner. Monitor: Beginning 03/03/2017, handrail audits will be completed by the Maintenance Director: weekly for 2 weeks and monthly for 2 months. Corrective measures will be reported in the monthly QAPI meeting by the Maintenance Director. The Administrator is responsible for monitoring.		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-  (i) Complete;  (ii) Accurately documented;  (iii) Readily accessible; and  (iv) Systematically organized  (5) The medical record must contain-  (i) Sufficient information to identify the resident;  (ii) A record of the resident's assessments;  (iii) The comprehensive plan of care and services	F 514		3/3/17	

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>01/27/2017</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 44 provided;</p> <p>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;</p> <p>(v) Physician's, nurse's, and other licensed professional's progress notes; and</p> <p>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy review, and resident and staff interviews, it was determined the facility failed ensure each residents' clinical records were complete and accurate. This was true for 1 of 6 sampled residents (#3) whose behavioral records were reviewed. This failed practice increased the risk for medical decisions to be based on incomplete or inaccurate behavioral information. Findings include:</p> <p>Resident #3 was readmitted to the facility on 1/26/11, with diagnoses of bipolar disorder, major depressive disorder, and anxiety disorder.</p> <p>Resident #3's Physician Orders dated January 2017 included:</p> <p>* Fluoxetine 10 mg every other day for depression * Olanzapine 2.5 mg daily at bedtime for bipolar disorder</p> <p>Resident #3's most recent comprehensive MDS assessment, dated 11/14/16, documented</p>	F 514	<p>On 01/30/2017, Resident #3 was assessed by the Licensed Social Worker for signs and symptoms of increased behaviors or psycho-social harm, finding none.</p> <p>On or before 03/03/2017, Resident #3's Behavioral Monitoring Interventions flow sheets will be reviewed for the last 30 days by the Center Nurse Executive or designee for omitted documentation. Follow-up education was completed for center staff who did not document on the behavior flow record.</p> <p>Potential: On or before 03/03/2017, 30 days of behavior flow sheets will be reviewed for accurate documentation of resident behavior.</p> <p>Systemic: Center staff responsible for documenting resident behaviors will be re-educated by the Nurse Practice Educator on or before 03/03/2017 related to documentation requirements for resident behaviors, including the use of the behavior flow</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>01/27/2017</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 45</p> <p>Resident #3 was cognitively intact, had no signs of depression, no hallucinations, delusions, and no physical or verbal behavioral symptoms.</p> <p>Resident #3's care plan for, "at risk for complications related to use of psychotropic drugs," dated 3/19/15 and revised on 1/4/16, directed staff to complete the behavior monitoring flow sheet and monitor for Resident #'s continued need of medication as related to behavior and mood.</p> <p>Resident #3's care plan of, "expressed the wish to die," dated 8/14/15 and revised on 1/4/16, directed staff to assess her for distressing symptoms i.e. negative statements regarding end of life care and if negative statements are expressed, ensure her safety, and initiate suicide precautions, when needed.</p> <p>Resident #3's care plan, dated 4/16/14 and revised on 8/10/15, documented Resident #3, "exhibited inappropriate behavior: disbelief in value of treatment, hx of refusing medications, physical aggression as evidenced by hitting staff, throwing items at staff, resisting care, self-isolation, verbal aggression and paranoia with repetitive questions over tasks being performed." Staff were directed to have 2 staff in the room if Resident #3 was agitated.</p> <p>Resident #3's Behavior Monitoring and Interventions Logs for October, November, and December 2016, and January 2017, were reviewed. The logs provided a space to document the occurrence of target behaviors on each shift. Target behaviors and episodes of target behaviors were as follows:</p>	F 514	<p>sheet.</p> <p>On or before 03/03/2017 the Licensed Social Worker or designee will present the behavior monitors to the IDT team weekly in the CAR meeting to ensure the documentation is completed per facility policy.</p> <p>Monitor: Beginning 03/03/2017 the Center Nurse Executive or designee will audit behavior monitors: weekly times 4 weeks, then monthly times 3 months. Findings will be reviewed in the QAPI meeting for 3 months. The Center Nurse Executive will monitor compliance.</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>01/27/2017</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 46</p> <p>*Throwing items at others - No occurrences documented</p> <p>*Refusing cares - One occurrence documented for 12/28/16</p> <p>*Explosive anger/yelling at others - No occurrences documented</p> <p>.</p> <p>*Self-isolation of demanding that her door is closed [initiated 12/14/16]:</p> <ul style="list-style-type: none"> <li>- Occurrences were documented on the day shift from 12/14/16 through 12/31/16 [18 days].</li> <li>- Occurrences were documented on the day shift 11 days in January [1-3, 8-10, 15-17, 22, and 23].</li> </ul> <p>A 12/27/16 nursing progress note documented Resident #3, "refused bowel care." The refusal was not documented on her Behavior Monitoring and Interventions flowsheet for refusal of care.</p> <p>A 12/28/16 nursing progress note documented Resident #3, "refused to allow CNA to change soiled bed sheets." The refusal was not documented on Resident #3's Behavior Monitoring and Interventions flowsheet for refusal of care.</p> <p>Review of Resident #3's electronic Psychotherapeutic Medication Use Evaluation form, dated 12/30/16, assessed for, "behavior trends since last evaluation," and referred the reader to the Behavior Monitoring and Intervention flow record and Nursing/Social Service progress notes. The evaluation documented Resident #3's behavior symptoms had increased with "explosive anger - yelling at</p>	F 514			

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

PRINTED: 03/03/2017  
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>01/27/2017</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 47</p> <p>others" occurring once in December 2016. The evaluation documented no such occurrences November 2016. The Interdisciplinary Team documented a gradual dose reduction was NOT recommended as Resident #3 refused redirection, had ongoing irritability, and a past history of exacerbation of bipolar symptoms.</p> <p>A Psychiatric Progress Note, dated 1/9/17, documented, "Staff report the resident wants the door shut all of the time, otherwise, there is no major change in her behavior or mood. The resident did not want to talk to me much but today was the best I have seen her. Resident is cooperative, [her] mood is fine, [her] insight and judgement is impaired.</p> <p>A 1/10/17 nursing progress note documented Resident #3, "refused bowel care and when RN attempted to educate resident on bowel care she asked me to leave the room and close the door." This was documented on the Behavior Monitoring and Interventions for self-isolation/demanding that her door be closed. It it was not documented on the Behavior Monitoring and Interventions flow record for refusal of care.</p> <p>A facility policy titled, Behavior Monitoring and Interventions Flow Record Instructions, effective date 7/1/14, directed nursing staff to complete the Behavior Monitoring and Interventions flow record documentation by exception only. No documentation indicated the behavior did not occur on that shift/day.</p> <p>Resident #3's Behavior Monitoring and Interventions Logs between 12/27/16 and</p>	F 514			

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>01/27/2017</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 48</p> <p>1/17/17, documented 1 episode of refusing care on 12/28/16 during the day shift and 14 episodes of self-isolating and demanding the door to be closed was noted on the day shift only.</p> <p>The door to Resident #3's room was observed closed as follows:</p> <p>* On 1/23/17, at 10:30 am, 1:10 pm, and 3:00 pm, the door to Resident #3's room was observed closed.</p> <p>* On 1/25/17, Resident #3's door was closed when observed at 10:00 am and 4:00 pm.</p> <p>* On 1/26/17 Resident #3's door was observed to be closed at 10:30 am, 12:05 pm, 2:00 pm, 4:00 pm, and 5:30 pm.</p> <p>Resident #3's door was observed closed on both the day and evening shifts.</p> <p>On 1/24/17 at 10:15 am, Resident #3 participated in a conversation with a surveyor and answered 2 questions. She stated she liked the door to her room closed and she will only eat peanut butter and jelly, white bread, no crust for lunch and dinner." She stated, "I never eat breakfast." Resident #3 then stated, "That's all."</p> <p>Resident #3's Behavior Monitoring and Interventions flow sheets did not include accurate documentation of her targeted behaviors.</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  <b>01/27/2017</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	<p>16.03.02 INITIAL COMMENTS</p> <p>The following deficiencies were cited during the State Licensure and complaint survey conducted at the facility from January 23, 2017 January 27, 2017.</p> <p>The surveyors conducting the survey were:</p> <p>Teresa Kobza, RDN/LD, Team Coordinator Nina Sanderson, LSW Susan Costa, RN Edith Cecil, RN</p>	C 000		
C 490	<p>02.121,05,d,vii Meet Minimal Personal Storage Requirements</p> <p>vii. Each patient/resident shall be provided, within the room, a wardrobe, locker or closet with a minimum of four (4) square feet. Common closets are not permitted. An adjustable clothes rod and adjustable shelf shall be provided; This Rule is not met as evidenced by: Based on staff interview, it was determined the facility failed to ensure residents were provided with the required closet space of 20 inches wide by 22 inches deep, for 1 of 3 halls (the 100 hall). This included all closets in rooms 201 and 203. Findings include:  During survey, the Administrator indicated a waiver would again be requested to allow for less than the required closet space. All 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.</p>	C 490	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, River Ridge Care and Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p>	3/3/17

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE  02/17/17
--	-------	---------------------------

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>01/27/2017</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 490	Continued From page 1	C 490	On or before 03/03/2017, the Center Executive Director will request a waiver for the affected closets.	
C 664	<p>02.150,02,a Required Members of Committee</p> <p>a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on staff interview and review of the Infection Control Committee (ICC) meeting attendance records, it was determined the facility failed to ensure a representative from each required department attended the ICC quarterly meetings. The lack of participation of these departments created the potential for negative outcomes for residents, visitors, and staff in the facility. Findings include:</p> <p>On 1/24/17 at 11:00 am, the facility's Infection Control Program was reviewed with the Infection Preventionist (IP). The IP provided ICC attendance records dated as follows:</p> <p>1/22/2016 for December 2015 2/26/16 for January 2016 2/25/16 for February 2016 4/22/16 for March 2016 4/22/16 for April 2016 5/20/16 for May 2016 6/16/16 and 6/17/16 for June 2016 7/22/16 for July 2016 8/26/16 for August 2016 9/30/16 for September 2016 10/21/16 for October 2016</p>	C 664	<p>On or before 03/03/2017, the Center Executive Director will ensure the Pharmacist and Housekeeping Supervisor attend the QAPI meeting each Quarter.</p>	3/3/17

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>01/27/2017</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 664	Continued From page 2 12/8/16 and 12/16/16 for November 2016.  The records received documented the following:  1. A signature representing a pharmacist could not be identified as attending any meeting in the third and fourth quarters (July 2016 through December 2016.) 2. A signature representing a housekeeping services representative could not be identified as attending any meeting in the fourth quarter (October 2016 through December 2016).	C 664		
-------	--	-------	--	--



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR  
LICENSING & CERTIFICATION  
DEBBY RANSOM, R.N., R.H.I.T – Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
FAX: (208) 364-1888  
E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

April 11, 2017

James Hayes, Administrator  
Payette Center  
1019 Third Avenue South  
Payette, ID 83661-2832

Provider #: 135015

Dear Mr. Hayes:

On **January 27, 2017**, an unannounced on-site complaint survey was conducted at Payette Center. This complaint was investigated in conjunction with the facility's recertification survey between January 23 and January 27, 2017.

During the survey, observations of resident care and privacy were made over a four day period. The identified resident had discharged from the facility, so the resident's record was reviewed. The records of ten other residents were reviewed, with record reviews including two residents on hospice and four residents identified as having moderate or severe pain. Ten resident records were reviewed for privacy, choice, and the provision of medically related social services. Three individual residents and two resident families were interviewed regarding pain management, privacy, confidentiality, and choice. A resident group interview was conducted. Several nurses and nurse's aides were interviewed. The facility Administrator, Director of Nursing, and Social Worker were interviewed.

The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007291**

**ALLEGATION #1:**

The facility disclosed an identified resident's name and room number to a hospice agency without consent from the resident or the resident's responsible party. The facility did not respect the resident's right to not enroll in hospice services.

#### FINDINGS:

In review of the identified resident's record, it was discovered the resident had been admitted to the facility from an acute care hospital. While in the hospital, the identified resident's record documented a number of disease processes which met the definition of a terminal illness, and treatment options for these conditions had previously been exhausted. The resident had chronic pain related to these diagnoses. A palliative care consultation was conducted with the resident and family members while in the hospital to discuss the option of enrolling in hospice. The resident ultimately decided on placement in the nursing home to work with therapy services in an effort to get strong enough to return home. The resident chose not to enroll in hospice at that time.

Once admitted to the facility, there was no documentation the subject of hospice was introduced again to the resident. The identified resident began to work with physical and occupational therapy, with a goal of returning home. While in the facility, the resident was seen by both the primary care physician and the oncologist. Approximately a week after the oncology appointment, the resident and a family member met with the primary care provider to inform that provider of the intent to return home with hospice. The resident left the facility on a pass with the family member that day, and did not return to the facility. The resident did not meet with- or enroll in hospice services at the time of discharge.

The facility Social Worker stated that on the date the resident discussed the intent to discharge home with hospice, the facility received a call from another family member informing the facility that family had contacted a hospice agency and made an inquiry regarding hospice services. The Social Worker stated that a short time later, a representative from the identified hospice agency arrived at the facility and asked for the identified resident by name. Since another family member was with the resident at the time, and the facility had reason to believe the hospice provider had been invited by family to see the resident, the resident's room number was provided. The Social Worker stated the family member in the room with the resident became upset with the hospice agency's presence and blocked them from entering the room. That same day, the resident went out on a pass with family and did not return to the facility. When the Social Worker called family to check on the resident, the facility was informed the resident would remain at home and had enrolled with hospice services from a different agency.

Other residents and families of other residents receiving hospice services in the facility had no concerns about how the referrals to hospice had been handled by the facility.

There was insufficient evidence to substantiate this allegation, and no deficiencies related to this allegation were cited.

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

James Hayes, Administrator  
April 11, 2017  
Page 3 of 3

ALLEGATION #2:

An identified resident did not have adequate pain control.

FINDINGS:

The identified resident's record documented a number of diagnoses which caused ongoing pain, as well as the resident's preference to avoid medications which may cause increased abdominal pain or constipation. However, the record provided to the facility when the resident was admitted from the hospital documented the resident was receptive to, and did receive, an over-the-counter pain medication which did not cause abdominal pain or constipation, but did provide effective relief. The resident received occasional narcotic pain medication in the facility, but the effectiveness of that medication was not documented.

This allegation was substantiated and cited at F 309.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this 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 David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. 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 blue ink that reads "D. Scott". The signature is written in a cursive style with a large initial "D" and a clear "Scott" following.

David Scott, R.N., Supervisor  
Long Term Care

DS/lj



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR  
LICENSING & CERTIFICATION  
DEBBY RANSOM, R.N., R.H.I.T – Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
FAX: (208) 364-1888  
E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

April 11, 2017

James Hayes, Administrator  
Payette Center  
1019 Third Avenue South  
Payette, ID 83661-2832

Provider #: 135015

Dear Mr. Hayes:

On **January 27, 2017**, an unannounced on-site complaint survey was conducted at Payette Center. The complaint was investigated during a Federal Recertification and Complaint Investigation Survey conducted January 23, 2017 to January 27, 2017.

Immediately after entering the facility, the survey team conducted a general tour of residents' rooms and common areas. Throughout the survey, eleven individual residents and all residents in general, were observed for quality-of-care, signs of distress, and quality-of-life issues. In addition, facility staff was observed as they provided catheter care, interacted with residents, and responded to residents' needs, call light response time, and other requests.

The clinical records of the identified resident and ten other residents were reviewed for quality-of-life, quality-of-care issues. Specifically, pressure ulcer and wound management, bathing practices, and catheter care were reviewed. The facility's grievance files and Incident and Accident Reports were also reviewed.

Interviews were conducted with multiple individual residents. Several direct care staff, including nurses and nursing aides, were also interviewed, as well as the Director of Nursing Services and the Wound Nurse. The interviews included questions about catheter care, skin assessments, quality-of-life and quality-of-care issues.

The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007444**

**ALLEGATION #1:**

The complainant stated the identified resident had a dark scab to her upper lip and red sores in the peri-area, and buttocks region.

**FINDINGS:**

The identified resident developed thrush in her mouth however no sores were identified on the outside of her mouth. The Director of Nursing Services stated the identified resident was started on antibiotics as soon as the thrush was discovered and the resident was discharged the day after the medication was initiated.

The clinical record documented the identified resident fell on her buttock on December 30, 2016 when attempting to get into bed and had not used the called light to ask for assistance. The facility performed a complete assessment of the identified resident's skin after the fall and found no issues. The identified resident's physician ordered an x-ray of the hip and pelvis region after the fall to help assess her for injuries. Facility staff documented peri-care was completed each shift and skin issues were found. The clinical record documented orders were written and medication was provided for the identified resident's thrush on January 1, 2017.

Based on interviews and record reviews the allegation was substantiated, however the documentation did not show she developed these skin impairments at the facility.

**CONCLUSIONS:**

Substantiated. No deficiencies related to the allegation are cited.

**ALLEGATION #2:**

The complainant stated the identified resident only received two showers during her stay in the facility.

**FINDINGS:**

Numerous observations were made throughout the facility. Interviews were conducted with multiple residents. Numerous clinical records were reviewed and a group interview was conducted. Other residents did not voice any concerns of not receiving showers.

James Hayes, Administrator  
April 11, 2017  
Page 3 of 4

The identified resident's clinical records documented a bed bath on December 23, 2016 and a shower on December 28, 2016. These two dates were the only documentation of a bath or shower in the clinical record. The identified resident was discharged from the facility on the morning of January 2, 2016.

Based on record review the allegation was substantiated, however regulatory requirements do not require more frequent bathing.

#### CONCLUSIONS:

Substantiated. No deficiencies related to the allegation are cited.

#### ALLEGATION #3:

The complainant stated the identified resident's suprapubic catheter was inserted incorrectly.

#### FINDINGS:

Residents interviewed did not voice any concerns about catheter care not being provided or checked for placement.

The Director of Nursing Services stated the identified resident fell on December 30, 2016, and the facility assessed her Foley catheter for proper placement after the fall. The Foley catheter was not found out of place.

The identified resident's clinical records contained an order for staff to perform Foley catheter care every evening and night shift. The identified resident's clinical records contained documentation the resident received catheter care on January 1, 2107. The catheter care for December 22, 2016 through December 31, 2016 could not be found.

Based on interviews and record review, the allegation was substantiated and cited at F315.

#### CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

#### ALLEGATION #4:

Staff did not respond to call lights in a timely manner.

James Hayes, Administrator  
April 11, 2017  
Page 4 of 4

**FINDINGS:**

Based on observations and interviews, call lights were not functioning correctly throughout the facility. This allegation was substantiated and cited at F463.

**CONCLUSIONS:**

Substantiated. Federal deficiencies related to the allegation are cited.

Based on the findings of the investigation, deficiencies were cited and included on the Statement of Deficiencies and Plan of Correction forms. No response is necessary to this 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 David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2. 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 "D. Scott". The signature is written in a cursive, slightly slanted style.

David Scott, R.N., Supervisor  
Long Term Care

DS/lj