



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
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TAMARA PRISOCK—ADMINISTRATOR
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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June 26, 2017

Candice Durham, Administrator
Prestige Care & Rehabilitation-- The Orchards
1014 Burrell Avenue
Lewiston, ID 83501-5589

Provider #: 135103

Dear Ms. Durham:

On **June 8, 2017**, a survey was conducted at Prestige Care & Rehabilitation-- The Orchards by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be an isolated 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.

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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 **July 3, 2017**. Failure to submit an acceptable PoC by **July 3, 2017**, may result in the imposition of penalties by **July 31, 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 **July 13, 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 **September 6, 2017**. A change in the seriousness of the deficiencies on **July 23, 2017**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **September 6, 2017** includes the following:

Denial of payment for new admissions effective **September 6, 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 **December 5, 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 **September 6, 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>

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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 **July 3, 2017**. If your request for informal dispute resolution is received after **July 3, 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 cursive script that reads "Nina Sanderson LSW".

Nina Sanderson, LSW, Supervisor
Long Term Care

NS/lj
Enclosures

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

PRINTED: 07/17/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135103	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/08/2017
NAME OF PROVIDER OR SUPPLIER PRESTIGE CARE & REHABILITATION - THE ORCHARDS			STREET ADDRESS, CITY, STATE, ZIP CODE 1014 BURRELL AVENUE LEWISTON, ID 83501		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The following deficiencies were cited during a complaint investigation survey completed at the facility from June 5, 2017 to June 8, 2017. The surveyors conducting the survey were: Teresa Kobza, RDN, LD, Team Coordinator Jenny Walker, RN Brad Perry, LSW Abbreviations include: ADL - Activities of Daily Living CC - Cubic Centimeter DNS - Director of Nursing Services CNA - Certified Nursing Assistant LMSW - Licensed Masters Social Worker LSW - Licensed Social Worker MAR - Medication Administration Record MDS - Minimum Data Set PRN - As Needed RCM - Resident Care Manager RN - Registered Nurse	F 000			
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;	F 157		7/17/17	

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

TITLE

(X6) DATE

Electronically Signed

06/30/2017

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.

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F 157	<p>Continued From page 1</p> <p>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);</p> <p>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or</p> <p>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).</p> <p>(ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.</p> <p>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or</p> <p>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review, and Interested Party</p>	F 157	This Plan of Correction is prepared and		

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F 157	<p>Continued From page 2</p> <p>and staff interview, it was determined the facility failed to ensure a resident's Interested Party was notified of significant changes in the resident's clinical condition. This was true for 1 of 5 (#5) sampled residents and had the potential for more than minimal harm when the facility failed to notify Resident #5's Interested Party when the resident began and continued to refuse evening meals. Findings include:</p> <p>Resident #5 was admitted to the facility on 2/28/17, with diagnoses including multiple sclerosis [MS], hospice, anxiety disorder, and muscle weakness.</p> <p>An admission Minimum Data Set [MDS] assessment, dated 3/7/17, documented Resident #5 required extensive assistance from, or was totally dependent on, staff for all cares including eating.</p> <p>Resident #5's Meal Intake Vitals Report, documented he refused the evening meal 13 of 32 days from 3/13/17 through 4/13/17. Four of the 13 days had a corresponding Progress Note which documented Resident #5 refused the evening meal. There was no documentation that Resident #5's Interested Party was informed of his meal refusals.</p> <p>On 6/7/17 at 1:34 pm, the DNS said she expected staff to notify the resident's Interested Party when a resident consistently refused meals.</p> <p>On 6/7/17 at 4:27 pm, Resident #5's Interested Party said he was not informed of the resident's refusal of the 13 evening meals.</p>	F 157	<p>submitted as required by law. By submitting this Plan of Correction, Prestige Care & Rehabilitation Center <input type="checkbox"/> The Orchards does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.</p> <p>F-157</p> <ol style="list-style-type: none"> 1) Resident #5 no longer resides in the facility. 2) Current residents meal intake records have been reviewed for resident Interested Parties notification for meal refusals. Notifications made and documentation completed, if needed. 3) Current Certified Nursing Assistants (NAC) staff have been re-educated on the importance of documenting resident meal acceptance in Point of Care (POC) following each meal, and need to notify the Licensed Nurse (LN) of any refusals, by the Director of Nursing (DNS) and/or designee. Current LN staff have been re-educated on notification of clinical condition changes, ie meal refusals, to residents Interested Parties, by the DNS and/or designee. <p>The Medical Records Director (MRD) will pull the POC ADL documentation report daily and forward to</p>		

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F 157	Continued From page 3	F 157	the RCMs and DNS. The RCMs will audit the daily POC reports for meal refusals and Interested Party notification documented in resident progress notes. The RCMs will forward copy of daily audits to the DNS for review and follow up if needed. 4) The DNS will track and trend audit findings and report results to the monthly Quality Assurance Performance Improvement (QAPI) Committee to identify opportunities for performance improvement x 3 months and randomly thereafter to maintain compliance. 5) The Administrator will ensure compliance. 6) Compliance date <input type="checkbox"/> 7/17/2017		
F 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on interviews with facility staff, hospice	F 242	This Plan of Correction is prepared and	7/17/17	

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F 242	<p>Continued From page 4</p> <p>staff, and a resident's Interested Party, and policy and record review, it was determined the facility failed to ensure residents were given the opportunity to make choices regarding meal times. This was true for 1 of 5 (#5) sampled residents. These deficient practices placed Resident #5 at risk of weight loss and a diminished sense of self-worth due to lack of control over his environment. Findings include:</p> <p>Resident #5 was admitted to the facility on 2/28/17, with diagnoses including multiple sclerosis [MS], vitamin D deficiency, anxiety disorder, muscle weakness, slurred speech, hospice, and end of life cares.</p> <p>Resident #5's admission Minimum Data Set [MDS] assessment, dated 3/7/17, documented he was cognitively intact, with some cognitive difficulties in new situations. The MDS documented he required extensive assistance from, or was totally dependent on, staff for all cares including bed mobility and eating.</p> <p>Resident #5's clinical record did not contain a comprehensive care plan to direct staff on how to manage his activities of daily living [ADL], dietary, and other needs.</p> <p>Resident #5's In-Room Care Plan, dated 2/28/17, did not include Resident #5's skill level with eating, whether he required assistance, and/or preferences regarding his evening meal time. The In-Room Care Plan documented Resident #5 "required" the head of his bed elevated at all times. It did not document whether pillows or devices were necessary to keep him in an up-right position. The In-Room Care Plan</p>	F 242	<p>submitted as required by law. By submitting this Plan of Correction, Prestige Care & Rehabilitation Center <input type="checkbox"/> The Orchards does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.</p> <p>F- 242</p> <ol style="list-style-type: none"> 1) Resident #5 no longer resides in the facility. 2) Current residents have been interviewed by the Social Services Director (SSD) to determine if facility meal times meet their usual and customary routines and preferences. Individual preferences will be honored, and Comprehensive Care Plans (CCP<input type="checkbox"/>s) and In Room Care Plans (IRCP<input type="checkbox"/>s) will be updated, if needed. 3) Current staff have been re-educated on the resident<input type="checkbox"/>s right to choose activities, schedules, health care providers consistent with his or her interests, assessments and plan of care. Also, that the resident has a right to make choices about aspects of his or her life, in the facility, that are significant to the resident, by the DNS and/or designee. Current staff have been re-educated on Prestige P & P for handling resident and Interested Parties concerns through the 		

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F 242	<p>Continued From page 5</p> <p>documented he was cognitively intact but could not communicate verbally.</p> <p>a. On 6/6/17 at 3:00 pm, the facility's Licensed Social Worker [LSW] stated when Resident #5 was admitted to the facility she sat down with him and his Interested Party and they told her Resident #5 preferred to eat meals earlier than the facility's scheduled times.</p> <p>A Hospice Registered Nurse [RN] note, dated 3/14/17 at 10:24 am, documented Hospice RN #1 spoke with the facility's LSW and a floor nurse regarding Resident #5's Interested Party's concerns with "feeding."</p> <p>On 6/7/17 at 10:00 am, Hospice RN #1 stated the concern with "feeding" brought to her attention by Resident #5's Interested Party was in regards to meal timing issues and an incident that occurred over the weekend.</p> <p>A Hospice Licensed Masters Social Worker [LMSW] note, dated 3/14/17 at 10:23 am, documented Resident #5's Interest Party spoke with her regarding his concerns with "meal times." The note documented Resident #5's Interested Party spoke with the facility's LSW about these concerns and the Hospice LMSW spoke with the facility's LSW, as well.</p> <p>On 6/6/17 at 3:00 pm, the facility's LSW stated she did not recall the 3/14/17 conversations with hospice agency staff or Resident #5's Interested Party. The LSW said she should have documented a note.</p> <p>On 6/7/17 at 11:59 am, the Hospice LMSW</p>	F 242	<p>Grievance process by the DNS and / or designee.</p> <p>Current Resident Care Managers (RCM's) have been re-educated on completion of the CCP and IRCP to reflect resident preferences and care needs by the DNS and / or designee. The current SSD has been re-educated on the need for documentation in resident clinical records of concerns discussed with Interested Parties and care providers, as well as communicating concerns to the Multi-disciplinary team (IDT) via the Grievance P & P, by the Administrator and / or designee. The SSD will discuss Resident's Rights for choices and individual preferences at the next Resident Counsel Meeting. Any voiced concerns will be recorded on a Grievance Form for follow up by the appropriate discipline. The SSD will report Grievance to the IDT the next morning at the Stand Up Meeting. The SSD will do random resident interviews (5 / week) regarding their individual preferences and choices being honored in the facility. Copies of the interviews will be forwarded to the Administrator and DNS for review and follow up, if needed.</p> <p>4) The SSD will track and trend resident interview responses and grievances related to choices and preferences and report results to the QAPI committee monthly, to identify opportunities for performance improvement x 3 months and randomly</p>		

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F 242	<p>Continued From page 6</p> <p>stated Resident #5's Interested Party notified her about his concerns with Resident #5's meal times and she spoke with a floor nurse and the LSW at the facility on 3/14/17.</p> <p>Resident #5's clinical record did not contain documentation of the conversations with facility staff above, except in the hospice notes.</p> <p>An untitled in-service, dated 4/14/17, documented "[Resident #5] will be receiving an early tray [every] day at 4 pm. Please wake him up to offer this meal[,] it is very important that we are providing 3 balanced meals each day to every resident. If he refused please let your nurse know. If his [Interested Party] brings in food and feeds him please find out how much and chart that amount. Make sure you are offering snacks to resident also, from facility supply and his own." The In-service document included the signatures of seven staff members as evidence they received the training. On 6/6/17 at 4:17 pm, the Director of Nursing Services [DNS] stated she was not aware of Resident #5's Interested Party's concerns regarding evening meal times and missed evening meals until hospice staff notified her on 4/13/17. She stated she in-serviced her staff on 4/14/17.</p> <p>On 6/7/17 at 4:27 pm, Resident #5's Interested Party stated he spoke with the facility's LSW, a Hospice RN, and a Hospice LMSW, about meal times on 3/14/17. He stated he understood the meals might not be exactly when Resident #5 was used to having them, however, he expected and thought staff would wake Resident #5 if he was sleeping. He stated he found out on 4/12/17, that Resident #5 was not eating evening meals</p>	F 242	thereafter to maintain compliance.		

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F 242	Continued From page 7 and if he was asleep staff were not waking him up to eat. He stated he discussed the concern with hospice personnel, the DNS, and the facility's LSW. The Interested Party stated the LSW told him Resident #5 would receive an early tray beginning 4/15/17. The Interested Party stated he was at the facility at 4:00 pm on 4/15/17. He stated from 4:00 - 6:00 pm a meal tray was not provided. He stated he had to ask staff for a meal tray, staff in the kitchen were still preparing meal trays, and Resident #5's meal tray had not yet been delivered. He stated the kitchen promptly prepared a sandwich and chicken noodle soup. The Interested Party stated he spoke with the facility's LSW about the meal not being provided early and possible discharge from the facility due to care concerns.	F 242			
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental	F 279		7/17/17	

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NAME OF PROVIDER OR SUPPLIER PRESTIGE CARE & REHABILITATION - THE ORCHARDS			STREET ADDRESS, CITY, STATE, ZIP CODE 1014 BURRELL AVENUE LEWISTON, ID 83501		
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F 279	<p>Continued From page 8 and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -</p> <p>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and</p> <p>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative (s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this</p>	F 279			

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F 279	<p>Continued From page 9 section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview and record review, it was determined the facility failed to ensure care plans based on residents' comprehensive assessments were developed and implemented. This was true for 1 of 5 residents (Resident #5) reviewed for initial care plans. This deficient practice created the potential for residents to experience physical and medical declines and/or complications, and decreased mood, due to unmet care needs. Findings include:</p> <p>Resident #5 was admitted to the facility on 2/28/17, with diagnoses including multiple sclerosis [MS], vitamin D deficiency, anxiety disorder, muscle weakness, slurred speech, hospice, and end of life cares.</p> <p>Resident #5's admission Minimum Data Set [MDS] assessment, dated 3/7/17, documented he was cognitively intact, with some cognitive difficulties in new situations. The MDS documented he required extensive assistance for all cares except bathing, for which he was totally dependent on staff. The Care Area Assessment documented areas of concern related to potential cognitive loss, communication difficulties, Activities of Daily Living [ADLs], urinary incontinence, altered nutritional status, pressure ulcer, and pain.</p> <p>The Preliminary Care Plan, dated 2/28/17, documented the following goals for Resident #5:</p> <ul style="list-style-type: none"> * Acclimate to the facility without difficulty * Have no falls/injury, as he was at high risk for 	F 279	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Prestige Care & Rehabilitation Center <input type="checkbox"/> The Orchards does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.</p> <p>F-279</p> <ol style="list-style-type: none"> 1) Resident #5 no longer resides in the facility. 2) Current residents clinical records have been reviewed for completion of a CCP and IRCP that accurately reflects resident care needs and updated as needed. 3) RCMs have been re-educated on the Resident Assessment Instrument (RAI) guidelines for timely completion of MDSs, CAAs and CCPs, and Prestige P & P for timely completion / updating of the IRCPs by the DNS and or designee. <p>The MRD will print out the MDS due and PPS due reports from Matrix each morning for review with the IDT during the morning Stand Up meeting. The DNS and RCMs will complete the</p>		

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F 279	<p>Continued From page 10</p> <p>falls</p> <ul style="list-style-type: none"> * No skin breakdown * Have desired pain relief * If he experienced exacerbation of cardiac or respiratory conditions the symptoms would subside with interventions in place * His weight will be maintained within acceptable parameters * Would tolerate meals without choking or aspiration, as he had a swallowing impairment * He would not have avoidable declines in ADLs * His incontinence would be managed by staff * Safe discharge to hospice * Communication impairment - types out words for staff * General/Pureed Diet * Hospice <p>The "Interventions" listed for each of the above care areas instructed staff to, "See in Room Care Plan" or "See in Room Care Plan for ADL Plans."</p> <p>Resident #5's In-Room Care Plan, dated 2/28/17, did not document Resident #5's skill level with eating or drinking and the level of assistance he required to eat. The In-Room Care Plan did not state he received hospice services. The plan documented Resident #5 was at risk of aspiration; swallowing precautions were not documented. The In-Room Care Plan documented Resident #5 required limited assistance with hair care, shaving, oral care, and extensive assistance for bathing. Resident #5's In-Room Care Plan was not consistent with his 3/7/17 MDS assessment, which documented he required extensive assistance for all cares except bathing, for which he was totally dependent on staff.</p>	F 279	<p>Checklist for IDT Review of MDS's due and completed each week. This includes MDS's done at Admission, Quarterly, Annually and with a Significant Change. Copies of the Checklists completed weekly, will be forwarded to the Administrator for review and follow up, as needed.</p> <p>The DNS will complete weekly random clinical records audit (5 per week) to ensure timely completion of CCP's and IRCP's and that they accurately reflect the resident's current condition and care needs. Copies of the audits will be forwarded to the Administrator for review and follow up, if needed.</p> <p>4) The DNS will track and trend audit findings and report results to the QAPI committee monthly, to identify opportunities for performance improvement x 3 months and randomly thereafter to maintain compliance.</p> <p>5) The Administrator will ensure compliance.</p> <p>6) Compliance date <input type="checkbox"/> 7/17/2017.</p>		

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F 279	Continued From page 11 Resident #5's records did not contain a comprehensive care plan which directed staff on how to manage his needs. On 6/6/17 at 4:17 pm, the Director of Nursing Services [DNS] stated the In-Room Care Plan was the only care plan for Resident #5. She stated the In-Room and Preliminary Care Plans were completed the first day a resident was admitted to the facility and the differences between Resident #5's MDS assessment and the In-Room Care Plan were because of this. She stated comprehensive care plans were typically generated beginning on day 21. The DNS stated the Resident Care Managers [RCM] were in charge of generating care plans. The DNS stated there should have been a comprehensive care plan in place for Resident #5. On 6/6/17 at 4:45 pm, RCM #2 stated the care plans in the chart were the only ones found for Resident #5. She stated the computer system did not have a comprehensive care plan created for Resident #5.	F 279			
F 325 SS=D	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable	F 325		7/17/17	

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F 325	<p>Continued From page 12</p> <p>body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;</p> <p>(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on staff interview, and review of facility policy and residents records, it was determined the facility failed to ensure residents received nutritional interventions to prevent unplanned weight loss. This was true for 1 of 3 residents (#5) sampled for weight loss. Resident #5 was placed at risk of more than minimal harm when his weight and food intake were not monitored and he experienced an unknown amount of weight loss. Findings include:</p> <p>1. Resident #5 was admitted to the facility on 2/28/17, with diagnoses including multiple sclerosis [MS], vitamin D deficiency, anxiety disorder, muscle weakness, slurred speech, hospice, and end of life cares.</p> <p>Resident #5's admission Minimum Data Set [MDS] assessment, dated 3/7/17, documented he was cognitively intact, with some cognitive difficulties in new situations. The MDS assessment documented he required extensive assistance from, or was totally dependent on, staff for all cares including bed mobility and eating. The MDS assessment documented Resident #5's height was 66 inches [5 foot 6 inches] and his admission weight was 127.5 pounds.</p>	F 325	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Prestige Care & Rehabilitation Center <input type="checkbox"/> The Orchards does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.</p> <p>F-325</p> <p>1) Resident #5 no longer resides in the facility.</p> <p>2) Current residents have had their clinical records reviewed for weight monitoring, and nutritional interventions to prevent unplanned weight loss. Review by Registered Dietician (RD) and CCP <input type="checkbox"/>s will be updated if needed.</p> <p>3) RCM <input type="checkbox"/>s have been re-educated on Prestige P & P for weight monitoring and review of residents during the weekly Nutrition at Risk (NAR) meeting, by the</p>		

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F 325	<p>Continued From page 13</p> <p>Resident #5's clinical record did not contain a comprehensive care plan to direct staff on how to address his activities of daily living [ADL] and dietary requirements.</p> <p>The In-Room Care Plan, dated 2/28/17, did not include Resident #5's skill level with eating, such as whether he required assistance, and/or whether he had preferences related to the evening meal. The care plan documented he was cognitively intact but could not communicate verbally.</p> <p>a. An admission Physician's Order from Hospice, dated 2/27/17, instructed facility staff to not weigh Resident #5.</p> <p>The Facility's Weight Monitoring and Documentation Policy stated "... Admission/readmission weights will be obtained within 24 hours...Weekly weights will be documented for a minimum of 4 weeks following admission and for residents at nutrition risk as determined by the dietitian and nutrition risk review..."</p> <p>Resident #5's Weight Vitals Report documented he weighed 127.5 pounds on 2/28/17, the day of his admission. Additional weights were not documented on the Weight Vitals Report.</p> <p>On 6/6/17 at 4:17 pm, the Director of Nursing Services stated the facility did not weigh Resident #5 because of the order from the hospice physician stating not weigh him. She stated this was a normal procedure for the facility to not weigh residents receiving hospice services</p>	F 325	<p>DNS and / or designee. Also, re-educated on completion of a CCP and IRCP that reflects the residents ADL and dietary preferences and care needs. Also re-educated on Interested Parties being notified when a resident has weight loss.</p> <p>4) The RCMs and DNS will pull the Weight Variance Report from Matrix weekly and review to ensure weights have been completed and identify residents who need to be assessed by the RD for nutritional interventions. The Medical Records Director (MRD) will pull the POC ADL documentation report daily and forward to the RCMs and DNS. The RCMs will audit the daily POC reports for meal refusals and Interested Party notification documented in resident progress notes. The RCMs will forward copy of daily audits to the DNS for review and follow up if needed.</p> <p>5) The DNS will track and trend audit findings and report results to the monthly Quality Assurance Performance Improvement (QAPI) Committee to identify opportunities for performance improvement x 3 months and randomly thereafter to maintain compliance.</p> <p>6) The Administrator will ensure compliance.</p> <p>7) Compliance date <input type="checkbox"/> 7/17/2017</p>		

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F 325	<p>Continued From page 14 if there was a physician's order not to do so.</p> <p>On 6/7/17 at 10:00 am, Hospice Registered Nurse [RN] #1 stated it was not protocol to weigh residents receiving hospice services. She stated she could tell Resident #5 was losing weight based on his appearance. She stated his clothes were looser and she could see it in Resident #5's face that he had lost weight.</p> <p>On 6/7/17 at 4:27 pm, Resident #5's Interested Party stated that on admission to the facility the decision about whether to weigh Resident #5 was not discuss with him and Resident #5. Resident #5's Interested Party stated he and Resident #5 were under the impression that weights would be completed while Resident #5 was in the facility. He stated they thought Resident #5 would be weighed at least on shower days. Resident #5's Interested Party said he did not know the hospice physician had ordered that Resident #5 not be weighed. The Interested Party stated he could see that Resident #5 was losing weight by the way his clothes were fitting and how his face looked.</p> <p>b. The Meal Intake Vitals Report, from 2/28/17 through 4/17/17, documented Resident #5's meal intake for each day. The Meal Intake Report documented Resident #5 refused 16 of 102 meals offered. The Meal Intake Vitals Report documented he did not receive 44 meals over the 47 day period since his admission, which was 31% of the meals. Resident #5's Meal Intake Vitals Report did not contain documentation for 24 evening meals, 12 lunches, and 8 breakfasts. There was no documentation of meal intake on 3/21/17, 3/24/17, 3/29/17, and 4/17/17.</p>	F 325			

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

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F 325	<p>Continued From page 15</p> <p>On 6/6/17 at 4:17 pm, the Director of Nursing Services [DNS] stated the missing documentation on the Meal Intake Vitals Record was missed charting opportunities or snacks were given to Resident #5 by his Interested Party without documenting the snacks. The DNS stated it had not been their policy to document snacks that the facility had not provided. The DNS stated she did not know there was missing documentation in the Meal Intake Vitals Records until the hospice staff called to discuss whether Resident #5 was getting his evening meal and that the evening meal time not to Resident #5's liking.</p> <p>On 6/7/17 at 10:00 am, Hospice RN #1 stated she thought Resident #5's weight loss was associated with the progression of his disease process. She did not know Resident #5 was refusing meals or did not consistently receive meals.</p> <p>On 6/7/17 at 11:59 am, the Hospice Licensed Masters Social Worker [LMSW] stated she was not aware that Resident #5 was not receiving meals until it was brought to her attention on 4/12/17 by Resident #5's Interested Party.</p> <p>On 6/7/17 at 4:27 pm, Resident #5's Interested Party stated Resident #5 could not communicate verbally and used a communication board. He stated Resident #5 was a very quiet individual and would not complain. He said the facility did not notify him when Resident #5 was refusing meals. The Interested Party stated he brought Resident #5 food for his evening meal about twice a week. The Interested Party said when he</p>	F 325			

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F 325	<p>Continued From page 16</p> <p>brought food he went to the nursing station and told a nurse and or a Certified Nursing Assistant [CNA] that they did not need to provide Resident #5 with an evening meal because he had provided one. The Interested Party stated around 4/10/17, he provided an evening meal for Resident #5 and went to the nursing station to tell someone and informed a CNA that he had brought an evening meal for Resident #5 and the facility did not need to provide one. The Interested Party stated the CNA told him 'Oh [Resident #5] does not eat dinner, he normally is asleep.' The Interested Party stated he asked Resident #5 if he was consistently provided with evening meals. The Interested Party said Resident #5 stated he must have been asleep when the meals were delivered and no one woke him up. The Interested Party said Resident #5 told him he did not get an evening meal on a consistent basis. Resident #5's Interested Party stated he discussed the issue with the facility's Licensed Social Worker.</p> <p>c. The Medical Nutrition Therapy [MNT] Assessment, dated 3/8/17, documented Resident #5 required "Limited Assistance" in regards to "Dining Ability." This was not consistent with Resident #5's admission MDS assessment, dated 3/7/17, which documented he required extensive assistance from, or was totally dependent on, staff for all cares, including eating. The Registered Dietician's [RD] "Recommendation" on the MNT assessment was, "Diet per MD order...update preferences as needed." The MNT assessment did not document Resident #5's height, weight, and estimated calorie, protein, and fluid needs.</p>	F 325			

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F 325	Continued From page 17 On 6/7/17 at 5:10 pm, the RD stated she had not been employed at the facility when Resident #5 lived there and would answer questions as best as she could. The RD said from reviewing the previous RD's work and notes, a height and weight was not in the medical record when the RD had completed her assessment on 3/8/17. She stated Resident #5's admission weight in the electronic record system must have been entered after 3/8/17. The RD stated she did not know if the previous RD checked the MDS assessment for a height and weight. The RD stated she saw the Meal Intake Vitals Records and did notice the missed entries. She stated the Meal Intake Vitals Records were part of the information used to assess residents. She stated the Meal Intake Vitals Records, as currently completed, would make it difficult to complete an accurate assessment.	F 325			
F 327 SS=D	483.25(g)(2) SUFFICIENT FLUID TO MAINTAIN HYDRATION (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (2) Is offered sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by:	F 327		7/17/17	

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F 327	<p>Continued From page 18</p> <p>Based on record review and interview with staff and a resident's Interested Party, it was determined the facility failed to ensure residents received sufficient fluids to meet hydration needs. This was true for 1 of 5 residents (#5) whose hydration needs were reviewed. This deficient practice created the potential for Resident #5 to become dehydrated and develop urinary tract infections, and/or experience other medical complications, due insufficient fluid intake. Findings include:</p> <p>Resident #5 was admitted to the facility on 2/28/17 with diagnoses including multiple sclerosis [MS], hospice, anxiety disorder, and muscle weakness.</p> <p>Resident #5's admission Minimum Data Set [MDS] assessment, dated 3/7/17, documented he required extensive assistance from, or was totally dependent on, staff for all cares including eating and drinking.</p> <p>Resident #5's In-Room Care Plan, dated 2/28/17, did not document Resident #5's skill level or whether he required assistance with eating and drinking.</p> <p>Resident #5's records did not contain a comprehensive care plan directing staff how to manage his dietary and hydration needs.</p> <p>According to the Nutrition Care Manual "Methods for Estimating Fluid Requirements" from the Academy of Nutrition and Dietetics, adults within Resident #5's age range should consume 30 cc [cubic centimeters] per kilogram of body weight per day. Using this calculation method, Resident</p>	F 327	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Prestige Care & Rehabilitation Center <input type="checkbox"/> The Orchards does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.</p> <p>F-327</p> <p>1) Resident # 5 no longer resides in the facility.</p> <p>2) Current residents clinical records have been reviewed to identify those at risk of dehydration due to need for staff assistance to consume fluids. CCPs and IRCPs have been updated, if needed.</p> <p>3) Current NACs have been re-educated on offering residents fluids with each contact, and documentation of fluids consumed throughout the shift, including from the bedside pitcher, by the DNS and / or designee. RCMs have been re-educated on including a residents daily fluid needs, based on the RD assessment, on the CCP and I RCP when at risk for dehydration by the DNS and/ or designee. Residents at risk of insufficient fluid intake will be reviewed in the weekly NAR</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135103	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/08/2017
NAME OF PROVIDER OR SUPPLIER PRESTIGE CARE & REHABILITATION - THE ORCHARDS			STREET ADDRESS, CITY, STATE, ZIP CODE 1014 BURRELL AVENUE LEWISTON, ID 83501		
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F 327	Continued From page 19 #5 needed a total daily fluid intake of 1737 cc's. The Vitals Report for total fluid intake, from 2/28/17 through 4/17/17, documented Resident #5's total fluid intake for each day. Resident #5 received the highest total fluid intake of 1680 cc on 3/14/17. Resident #5 received the lowest total fluid intake of 240 cc on 3/9/17 and 4/16/17. Resident #5's average fluid intake for the dates above was 661 cc's. Resident #5 refused some fluid offers 9 of 47 days. There was no documentation of fluid intake or refusals on 3/21/17, 3/24/17, 3/29/17, 4/14/17, and 4/17/17. On 6/7/17 at 1:34 pm, the DNS said Resident #5 had a water pitcher at the bedside, but depended on staff to assist with holding the water pitcher and offering fluids throughout the day. On 6/7/17 at 4:27 pm, the Interested Party said when Resident #5 was admitted to the facility, he visited Resident #5 at least 2-3 times every day. The Interested Party said on a few occasions Resident #5's water pitcher was empty and he filled it up and notified the staff.	F 327	meeting to identify interventions needed to prevent dehydration. 4) The DNS will do random Audits of resident clinical records (3 /week) for those who require assistance with consuming food and fluids, for accurate CCP and IRCP that reflect the risk of insufficient fluid intake and risk for dehydration. The DNS will track and trend audit findings and report results to the QAPI committee monthly, to identify opportunities for performance improvement. 5) The Administrator will ensure compliance. 6) Compliance date <input type="checkbox"/> 7/17/2017		
F 526 SS=D	483.70(o)(1)-(4) Hospice (o) Hospice services. (1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with	F 526		7/17/17	

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F 526	<p>Continued From page 20</p> <p>a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.</p> <p>(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:</p> <p>(i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.</p> <p>(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:</p> <p>(A) The services the hospice will provide.</p> <p>(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.</p> <p>(C) The services the LTC facility will continue to provide based on each resident's plan of care.</p> <p>(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to</p>	F 526			

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F 526	<p>Continued From page 21</p> <p>ensure that the needs of the resident are addressed and met 24 hours per day.</p> <p>(E) A provision that the LTC facility immediately notifies the hospice about the following:</p> <p>(1) A significant change in the resident's physical, mental, social, or emotional status.</p> <p>(2) Clinical complications that suggest a need to alter the plan of care.</p> <p>(3) A need to transfer the resident from the facility for any condition.</p> <p>(4) The resident's death.</p> <p>(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.</p> <p>(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.</p> <p>(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation</p>	F 526			

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F 526	<p>Continued From page 22</p> <p>of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.</p> <p>(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.</p> <p>(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.</p> <p>(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.</p> <p>(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to</p>	F 526			

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F 526	<p>Continued From page 23</p> <p>assess the resident or have access to someone that has the skills and capabilities to assess the resident.</p> <p>The designated interdisciplinary team member is responsible for the following:</p> <p>(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.</p> <p>(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.</p> <p>(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.</p> <p>(iv) Obtaining the following information from the hospice:</p> <p>(A) The most recent hospice plan of care specific to each patient.</p> <p>(B) Hospice election form.</p> <p>(C) Physician certification and recertification of the terminal illness specific to each patient.</p> <p>(D) Names and contact information for hospice personnel involved in hospice care of each</p>	F 526			

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F 526	<p>Continued From page 24 patient.</p> <p>(E) Instructions on how to access the hospice's 24-hour on-call system.</p> <p>(F) Hospice medication information specific to each patient.</p> <p>(G) Hospice physician and attending physician (if any) orders specific to each patient.</p> <p>(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.</p> <p>(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.20. This REQUIREMENT is not met as evidenced by: Based on record review and hospice and facility staff interview, it was determined the facility failed to ensure a hospice care plan was available to staff and a resident's care was coordinated with hospice staff. This was true for 1 of 1 (#5) resident sampled for hospice care. Facility staff did not communicate Resident #5's evening meal refusals as part of the coordination of care. This failure had the potential for more than minimal harm if Resident #5 did not receive services necessary to meet his dietary and other needs</p>	F 526	<p>This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Prestige Care & Rehabilitation Center <input type="checkbox"/> The Orchards does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative</p>		

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F 526	<p>Continued From page 25</p> <p>due to a lack of care coordination. Findings include:</p> <p>Resident #5 was admitted to the facility on 2/28/17 with diagnoses including multiple sclerosis [MS] and hospice.</p> <p>a. Resident #5's 2/27/17 physician orders, documented an order for hospice services.</p> <p>Resident #5's Preliminary Care Plan, dated 2/28/17, documented, "Hospice" with an intervention to "See In Room Care Plan for ADL Plans." No other information regarding hospice was documented.</p> <p>Resident #5's 2/28/17 In-Room Care Plan included a box to be checked if he was on hospice. The box was not checked. No other information regarding Resident #5's hospice services were documented.</p> <p>Resident #5's admission Minimum Data Set [MDS] assessment, dated 3/7/17, documented he required extensive assistance from, or was totally dependent on, staff for all cares including eating. The MDS assessment documented Resident #5 received hospice services.</p> <p>On 6/6/17 at 4:45 pm, the DNS said the facility did not develop a hospice care plan for Resident #5.</p> <p>b. Resident #5's Meal Intake Vitals Report noted he refused the evening meal 13 of 32 days from 3/13/17 to 4/13/17. Four of the 13 days had a corresponding Progress Note, which documented Resident #5 refused the evening meal. Resident</p>	F 526	<p>proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.</p> <p>F-526</p> <ol style="list-style-type: none"> 1) Resident #5 no longer resides in the facility. 2) There are no current residents receiving Hospice services. 3) RCMs have been re-educated to meet with Hospice RN weekly when a resident is receiving Hospice services to co-ordinate a CCP that meets the resident needs, by the DNS and or designee. Also, that changes in resident condition need to be reported to both the Hospice RN and Interested Parties. 4) The DNS will review future resident's clinical records that are receiving Hospice services, for an integrated CCP that has been developed between Hospice and the facility to meet the individualized needs of the resident. 5) The Administrator will ensure compliance. 		

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F 526	<p>Continued From page 26</p> <p>#5's record did not include documentation that hospice staff was informed of the evening meal refusals.</p> <p>On 6/7/17 at 10:00 am, Hospice Registered Nurse #1 said the facility did not inform the hospice agency of Resident #5's evening meal refusals.</p> <p>On 6/7/17 at 11:59 am, the Hospice Agency Licensed Master's Social Worker said the facility did not inform the hospice agency of Resident #5's evening meal refusals.</p> <p>On 6/7/17 at 4:45 pm, Resident Care Manager [RCM] #1, with the DNS and RCM #2 present, said the hospice agency staff serving Resident #5 did not always communicate to facility staff that they were in the building for a visit. RCM #2 said facility staff did not inform the hospice agency staff about Resident #5's evening meal refusals. RCM #2 said hospice staff approached the facility nurse or RCM when there was a concern about Resident #5.</p>	F 526			



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON– Director

TAMARA PRISOCK—ADMINISTRATOR
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July 19, 2017

Candice Durham, Administrator
Prestige Care & Rehabilitation-- The Orchards
1014 Burrell Avenue
Lewiston, ID 83501-5589

Provider #: 135103

Dear Ms. Durham:

On **June 8, 2017**, an unannounced on-site complaint survey was conducted at Prestige Care & Rehabilitation - The Orchards. The Complaint was investigated during a Complaint Investigation Survey conducted June 5, 2017 to June 8, 2017.

Immediately after entering the facility, the survey team conducted a general tour of residents' rooms and common areas. Throughout the survey, three 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 were observed providing care, interacting with residents, responding to call lights, repositioning residents, providing hydration, and providing residents with meal assistance and other requests.

The clinical records of the identified residents and four other residents were reviewed for quality of life and quality of care concerns, including hospice coordination, weight loss, hydration, accommodation of needs, care planning, and notification of condition change. The facility's grievance file and Incident and Accident reports were reviewed.

Interviews were conducted with multiple individual residents and the identified resident's interested party. Several direct care staff, including nurses and nursing aides, were also interviewed, as well as the Director of Nursing Services, Social Worker, and hospice employees. These interviews included questions about medication management, quality of life, physician rounding, and quality of care issues.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007515

ALLEGATION #1:

The facility did not provide meals at an earlier time when requested by the identified resident and his interested party.

FINDINGS #1:

Based on interviews with residents and interested parties, and record review, there were concerns identified with residents' wishes not being taken into consideration in regards to meal times.

Based on observation, interviews, and record review, the allegation was substantiated and cited at F242, F526, and F279. Please refer to federal 2567 report for details.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

The facility did not consistently provide the identified resident with dinner.

FINDINGS #2:

Based on interviews with residents' interested parties, the facility's Social Worker, Director of Nursing Services, and record review there were concerns identified related to the facility not providing meals. The resident's clinical record documented the identified resident was not provided multiple breakfast, lunch, and dinner meals throughout his stay at the facility.

Based on observation, interviews, and record review, the allegation was substantiated and cited at F325. Please refer to federal 2567 report for details.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #3:

There was an insufficient number of staff to assist residents requiring help eating.

FINDINGS #3:

Based on observations and interviews with staff and residents, there were no concerns identified with residents who required staff assistance with eating. Three meal observations took place throughout the survey and dining assistance was provided to all residents in the assisted dining room by three-to-four staff members. The assisted dining room also contained four-to-six residents at the time of the

observations.

Residents interviewed did not express concerns about meal times or having their assistance needs met by staff.

Based on observation and interviews, the allegation could not be substantiated due to lack of sufficient evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

The interested party and the identified resident's physician were not notified when dinner meals were refused on multiple occasions.

FINDINGS #4:

Based on interview with the Director of Nursing Services and record review there were concerns identified with the facility not notifying the identified resident's interested party and physician when the resident refused dinner meals. The identified resident's records did not contain documentation that the facility notified the physician or the interested party.

Based in interview and record review the allegation was substantiated and cited at F157. Please refer to federal 2567 report for details.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #5:

The identified resident was not provided adequate fluids.

FINDINGS #5:

Based on an interview with the Director of Nursing Services and record review, there were concerns identified with the facility not providing sufficient fluids. The identified resident's records documented an average of less than half his estimated needs were provided. The identified resident's clinical record identified multiple days no fluid was provided.

Based in interview and record review the allegation was substantiated and cited at F327. Please refer to

federal 2567 report for details.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #6:

The identified resident was poorly positioned in bed and the call light was not within reach to call for staff assistance.

FINDINGS #6:

All residents in general were observed for proper positioning and no concerns were identified. Call light response times and call light accessibility was observed and no concerns were identified throughout survey. Residents who were interviewed did not express concerns related to poor positioning or call light accessibility.

Based on observation, interviews and record review, the allegation could not be substantiated due to lack of sufficient evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #7:

The facility did not offer the identified resident a dietary supplement because weight loss was "expected."

FINDINGS #7:

The clinical record documented the identified resident refused the facility's offer of dietary supplements at the time of admission to the facility. The resident's interested party stated the identified resident did not like supplements and would not accept them if they were offered.

Based on interviews and record review, the allegation could not be substantiated due to lack of sufficient evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #8:

Candice Durham, Administrator
July 19, 2017
Page 5 of 6

The facility did not provide morning nebulizer treatments and would not wake the resident for these treatments.

FINDINGS #8:

The identified resident's clinical record documented nebulizer treatments were ordered on an as-needed basis and that these treatments were provided when needed on multiple days and throughout various shifts. Nursing staff interviewed stated nebulizer treatments were provided on an as-needed basis and the identified resident would occasionally refuse treatments.

Residents were observed receiving physician-ordered nebulizer treatments and stated they were provided treatments when they needed them.

Based on observation, interviews, and record review, the allegation could not be substantiated due to lack of sufficient evidence.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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



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July 19, 2017

Candice Durham, Administrator
Prestige Care & Rehabilitation - The Orchards
1014 Burrell Avenue
Lewiston, ID 83501-5589

Provider #: 135103

Dear Ms. Durham:

On **June 8, 2017**, an unannounced on-site complaint survey was conducted at Prestige Care & Rehabilitation - The Orchards. The complaint was investigated during an on-site complaint survey conducted from June 5, 2017 through June 8, 2017.

Call lights and call light response times were observed throughout the survey. Several residents were observed for call light and mobility device placement, bathing concerns, wound care, alternative meals, and therapy. Concerns about excessive noise was monitored throughout the survey.

The clinical records of the identified resident and four other residents were reviewed for Quality of Care concerns. The facility's Grievance files, Incident and Accident reports, abuse allegations, and menus were also reviewed.

Several residents, Certified Nursing Aides (CNAs) and nurses were interviewed regarding various Quality of Care and Quality of Life concerns. The Registered Dietician, Certified Dietary Manager, Maintenance Director, a Physical Therapist, Director of Therapy, Business Office Manager, Director of Nursing and Administrator were interviewed regarding various issues.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007527

ALLEGATION #1:

The Reporting Party stated an identified resident fell in the facility when staff did not answer the resident's call light or leave the resident's walker within reach.

FINDINGS #1:

The identified resident no longer resided in the facility at the time the complaint was investigated.

Call light placement and call light response times were observed throughout the survey and call lights were within reach of the residents; staff were observed to answer call lights in a timely manner. Two residents with fall risk preventions were observed for mobility device placement and no issues were identified.

The clinical record of the identified resident, including a fall Incident report, documented the call light and a mobility device were within reach at the time of the incident. The clinical records of two other residents with fall precautions did not document a concern with call light or mobility device placement.

Several residents, CNAs, and nurses said call lights and mobility devices were placed within reach and call lights were answered in a timely manner. The nurse on duty at the time of an identified resident's fall said the resident's call light and mobility device were within reach, but not used by the resident.

Based on observation, record review, and resident and staff interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

An identified resident was not bathed.

FINDINGS #2:

Several residents were observed for bathing concerns and no concerns were identified.

The clinical records of the identified resident and four other residents documented the residents were bathed appropriately.

Several residents, CNAs, and nurses said residents received the appropriate number of baths and showers per schedule.

Based on observation, record review, resident and staff interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

The identified resident's wound dressings were not changed.

FINDINGS #3:

Wound care was observed for a resident and the dressing was changed according to physician's order.

The clinical records of the identified resident and one other resident reviewed for wound care documented wound dressings were changed according to physician's orders.

A nurse and the Director of Nursing said residents received appropriate wound care according to physician's orders

Based on observation, record review and staff interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

An identified resident had difficulty chewing due to mouth sores, could only eat soup, and was not offered alternative meals.

FINDINGS #4:

Several residents were observed for alternative meal choices and no concerns were identified. The clinical record of the identified resident did not document the resident had mouth sores and did not document a concern regarding meals or meal alternatives. The facility's menu was reviewed and several alternatives were listed.

Several residents, CNAs, and nurses said an alternate menu was always offered if residents did not desire the main entree. The Registered Dietician and Certified Dietary Manager said residents were

offered an alternative meal and the kitchen staff would also help honor other meal requests. The identified resident's Interested Party said he/she had not observed sores in the resident's mouth.

Based on observation, record review, and resident and staff interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

An identified resident could not sleep because of other residents' noises and due to construction in the facility at night.

FINDINGS #5:

Staff were observed to quickly re-direct residents with disturbances and there was no construction noise noted throughout the survey.

The facility's Grievance file did not document a concern with noise at night.

Several residents said there were a few residents in the facility who called out or had repetitive language during the day, but staff were quick to help these residents and the facility was quiet at night. Several CNAs and nurses said the facility was quiet at night. The Maintenance Director said there had been no construction in the past several months, except for one occasion in which a door frame required some hammering near the identified resident's room, but that was in the afternoon and lasted only a few minutes on one day.

Based on observation, record review, resident and staff interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

An identified resident's physical therapist overworked- and was rude to the resident.

FINDINGS #6:

Several residents observed during therapy were provided rest periods and treated respectfully by therapy staff.

The clinical records of the identified resident and three other residents were reviewed for therapy concerns and no issues were identified regarding excessive therapy or rudeness by staff. The facility's Grievance files and abuse allegations did not document an issue with therapy overworking or abusing residents.

Several residents said they had no concerns with therapists pushing too hard and they were not rude or abusive. A Physical Therapist and the Director of Therapy said residents were not overworked and therapy sessions were appropriate for the level of need for each resident. They stated residents concerns are carefully considered and addressed and that residents are provided rests when they become tired.

Based on observation, record review, and resident and staff interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #7:

An identified resident was sent to the emergency room due to lack of bathing, dressing changes, and food intake.

FINDINGS #7:

Please refer to Findings #s 2-4.

The identified resident's hospital records documented the resident was admitted to the hospital related to his/her clinical diagnoses rather than a decline due to a lack of bathing, dressing changes, or food intake.

The Director of Nursing said the resident did not receive poor care while at the facility.

Based on observation, record review, and resident and staff interview, it was determined the allegation could not be substantiated.

Candice Durham, Administrator
July 19, 2017
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ALLEGATION #8:

An identified resident's Interested Party brought all of the concerns to the attention of facility staff, but the issues were not addressed.

FINDINGS #8:

The clinical records of the identified resident and Grievance file did not document concerns were brought to the facility's attention by the resident or an Interested Party.

Several residents said staff addressed their concerns in a timely manner. Several CNAs and nurses said resident- and family concerns were addressed in a timely manner. The Business Office Manager assigned to check in with the identified resident while at the facility stated the identified resident said any concerns had been addressed and that he/she was "happy with the facility." The Administrator said staff addressed resident concerns in a timely manner. When attempting to determine which staff the identified resident's Interested Party may have spoken to about concerns, the Interested Party chose not to respond.

Based on observation, record review, resident and staff interview, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

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

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