



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSS BARRON – 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
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May 30, 2018

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

Provider #: 135015

Dear Mr. Hayes:

On **May 18, 2018**, 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.

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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 **June 11, 2018**. Failure to submit an acceptable PoC by **June 11, 2018**, may result in the imposition of penalties by **July 2, 2018**.

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 **June 22, 2018 (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 **August 16, 2018**. A change in the seriousness of the deficiencies on **July 2, 2018**, 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 **August 18, 2018** includes the following:

Denial of payment for new admissions effective **August 18, 2018**. [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 **November 18, 2018**, 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 Debby Ransom, RN, RHIT, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 5; 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 **August 16, 2018** 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:

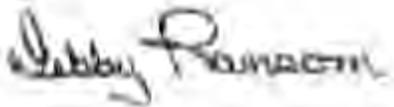
- BFS Letters (06/30/11)

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

This request must be received by **June 11, 2018**. If your request for informal dispute resolution is received after **June 11, 2018**, 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 Debby Ransom, RN, RHIT, Bureau Chief at (208) 334-6626, option 5.

Sincerely,



Debby Ransom, RN, RHIT, Chief
Bureau of Facility Standards

dr/lj
Enclosures

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

PRINTED: 06/14/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135015	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/18/2018
NAME OF PROVIDER OR SUPPLIER PAYETTE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 THIRD AVENUE SOUTH PAYETTE, ID 83661		
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F 000	INITIAL COMMENTS The following deficiencies were cited during the federal recertification and complaint survey conducted at the facility from May 14, 2018 through May 18, 2018. The surveyors conducting the survey were: Brad Perry, LSW, Team Coordinator Cecilia Stockdill, RN Survey Abbreviations: CNA = Certified Nursing Assistant CNE = Center Nurse Executive DM = Dietary Manager LPN = Licensed Practical Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment RD = Registered Dietician RN = Registered Nurse	F 000			
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity 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.	F 550		6/22/18	

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

TITLE

(X6) DATE

Electronically Signed

06/07/2018

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 550	<p>Continued From page 1</p> <p>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.</p> <p>§483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.</p> <p>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff interview, it was determined the facility failed to maintain an environment that enhanced residents' dignity and respect at meals, when staff placed clothing protectors on residents without their permission and/or did not offer cloth napkins instead of a clothing protector. This was true for 2 of 12 (#5 and #19) sampled residents, 1 random resident (#14) and any resident eating meals in the dining room. This practice created the potential for psychosocial harm if residents experienced embarrassment or a lack of</p>	F 550	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Payette Center does not Admit that the deficiencies listed on this form exist, nor does the center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies. The Center reserves the right to challenge in legal and or regulatory or administrative proceedings the deviancies, statements, facts, and</p>		

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F 550	<p>Continued From page 2</p> <p>self-esteem due to their appearance. Findings include:</p> <p>On 5/14/18 at 11:54 AM, 9 out of 10 residents in the dining room had clothing protectors on prior to lunch. CNA #3 placed clothing protectors on Residents #5 and #14 without asking if they wanted a clothing protector or a napkin.</p> <p>On 5/15/18 at 7:45 AM, prior to breakfast, CNA #4 offered Resident #14 a clothing protector, which was accepted. CNA #4 did not offer Resident #14 the choice of a cloth napkin. At 8:17 AM, all the breakfast trays, including Resident #14's, were served in the dining room with silverware wrapped up in cloth napkins.</p> <p>On 5/16/18 at 11:39 AM, prior to lunch, CNA #5 offered clothing protectors and did not offer napkins to Resident #5, #19 and #14, and each resident accepted the protectors. At 11:42 AM, CNA #5 said the cloth napkins were kept in the kitchen and were not available to staff until they came out with the meal trays. At 12:10 PM, Resident #5, #14 and #19 had a cloth napkin in place with their meals.</p> <p>On 5/16/18 at 1:50 PM, Resident #5 said she accepted a clothing protector only because the napkins were not offered until the meal tray arrived, and she would rather have a napkin.</p> <p>On 5/17/18 at 11:32 AM, the DM said the cloth napkins were kept in the kitchen where staff wrapped the silverware in them. She said there were no cloth napkins in the dining room, only clothing protectors.</p>	F 550	<p>conclusions that form the basis for the deficiencies."</p> <p>Affected: On or before 06/22/2018, CNA #3 and CNA #4 will receive counseling by the Center Nurse Executive or Designee regarding the requirement for staff to offer Residents a choice between a clothing protector or napkin.</p> <p>On 06/07/2018, Residents #5, #19 and #14 were assessed by the Licensed Social Worker for any adverse effects related to not being offered choice of a clothing protector or napkin with meal service.</p> <p>Potential: On or before 06/22/2018, the Center Executive Director or designee will complete a dining room audit for any identified dignity concerns including staff not offering napkins. Identified concerns will be addressed at the time of the review.</p> <p>Systemic: On or before 06/22/18, Staff assisting residents with meal service will receive training by the Center Nurse Executive or Designee on the facility policy which requires caregivers to offer residents a choice of a napkin and clothing protector.</p> <p>On or before 06/22/18, although napkins are provided on the meal service trays, the Food Service Director will insure</p>		

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F 550	Continued From page 3 On 5/17/18 at 11:56 AM, the CNE said she expected staff to ask residents if they wanted a cloth napkin or a clothing protector, and she would provide more education to the staff. The CNE said the clothing protectors offered to residents prior to the meal service were larger napkins with a snap and could be used either as a napkin or a clothing protector.	F 550	additional napkins are stocked in the dining room for those residents desiring one prior to the meal. On or before 06/22/18, staff assisting with meal service will be observed for compliance with dignity measures, including offering napkins, by the assigned Meal Service Manager. On or before 06/22/18, the Meal Service Managers will report in the daily stand-up meeting, on their observations and interventions, including staff interactions with residents when presenting clothing protectors and napkins. QAPI: On or before 06/22/2018, the Center Executive Director or Designee will complete 3 dining observations weekly X4 weeks and then monthly X2 months to ensure that residents are being treated with dignity including offering napkins with meal service. The results of the audits will be reported to the QAPI committee for review monthly X3 months or until substantial compliance is achieved.		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner.	F 565		6/22/18	

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F 565	<p>Continued From page 4</p> <p>(ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation.</p> <p>(iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings.</p> <p>(iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.</p> <p>(A) The facility must be able to demonstrate their response and rationale for such response.</p> <p>(B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.</p> <p>§483.10(f)(6) The resident has a right to participate in family groups.</p> <p>§483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, Resident Council meeting minutes, Resident Group interview, policy review, and staff interview, it was determined the facility failed to address Resident Council concerns. This was true for 4 of 5 (#2, #3, #12, and #18) residents in the Resident Group interview and those residents in the facility whose views and concerns were represented by the Resident Group. The deficient practice had the potential to</p>	F 565	<p>Affected:</p> <p>On or before 06/22/18, the Activity Director will review the grievances expressed by residents #3, #12, and #18. She will prepare a grievance report for each resident's concerns. The reports will be entered into the grievance system and followed-up. The center executive director or designee will investigate and</p>		

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F 565	<p>Continued From page 5</p> <p>cause psychosocial harm for residents frustrated by the perception their concerns were not valued or addressed by the facility. Findings include:</p> <p>Resident Council minutes documented: *9/18/17-Old business- Generalized complaints of the food. *10/17/17-New business- Complaints of the meat being too tough. *11/12/17-Old business- A resident requested a temperature log of food temperatures. New business-More choices of sugar-free drinks and complaints of cold food. *2/20/18-Old and New business-the food was improving. *4/17/18-Old business- Complaints that the food has not been good for the past two months and wanting more options for sugar-free drinks. The facility did not document what actions the facility took to resolve these concerns.</p> <p>The facility's Grievance policy, revised on 3/1/18, documented that grievances will be documented, investigated, have corrective actions taken, and the outcome would be reported back to the persons filling the grievance.</p> <p>On 5/15/18 at 1:34 PM, during the Resident Group interview, Residents #2, #3, #12, and #18 said the food concerns had been discussed during the Resident Council meetings with a staff member present, but the facility had not done enough to follow-up on these concerns because the food was still cold, lacked flavor, and they still did not have sugar-free drinks that tasted good. They also said, the DM told residents that she would let "corporate" know about the concerns, but then nothing would be done.</p>	F 565	<p>follow-up with the residents for resolution on or before 6/22/2018.</p> <p>Potential: On or before 06/22/18, a review of resident council meeting minutes for the last 90 days will be completed by the Activity Director to ensure that any identified grievances were investigated and resolved with resident follow-up.</p> <p>Systemic: On or before 06/22/18, the Center Executive Director will counsel the Activity Director on the importance of insuring resident concerns expressed in the Resident Council meeting are communicated to management via the Grievance system in order to insure timely resolution. On or before 06/22/18, the Activity director shall process the concerns and issues expressed in Resident Council by entering them into the facility Grievance system including follow-up a resolution. Resolutions will be reported to the Resident council.</p> <p>QAPI: On or before 06/22/2018, an audit of the resident council meeting minutes will be completed by the Center Executive Director or Designee monthly X 3 months to validate that resident grievances have been investigated and resolved. These audits will be reported to the QAPI committee monthly for review X3 months or until substantial compliance is</p>		

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

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F 565	Continued From page 6 On 5/16/18 at 2:10 PM, the Activity Director said she started in her position in June of 2017 and was in charge of taking the minutes for the Resident Council. She said she had verbally passed on the council's food concerns to the kitchen staff and had not filed grievances for these concerns. She said the Administrator and Social Worker had informed her about two months ago that she needed to file grievances on behalf of the Resident Council. The Activity Director said she had not filed grievances from the Resident Council in the last two months because she had been waiting for some additional training on the grievance process.	F 565	achieved. The Center Executive Director is responsible for monitoring and follow-up.		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the	F 578		6/22/18	

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F 578	<p>Continued From page 7</p> <p>facility's policies to implement advance directives and applicable State law.</p> <p>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.</p> <p>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.</p> <p>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, policy review, and staff interview, it was determined the facility failed to ensure a resident's clinical record accurately reflected the code/DNR (do not resuscitate) status. This was true for 1 of 12 (#28) sampled residents reviewed for advanced directive (wishes related to life sustaining measures) information. This failed practice created the potential for harm should the resident's wishes not be followed due to conflicting information in the clinical record. Findings include:</p> <p>The facility's policy and procedure regarding health care decision making, dated 1/1/13, documented the following:</p> <p>* At admission, the facility's admission designee</p>	F 578	<p>Affected:</p> <p>On or before 05/16/18, the Center Nurse Executive reviewed the POST with the resident number 28 and confirmed that she wanted to be DNR so noted review and changed physician order to match the POST with a new order received and processed on 5/16/2018.</p> <p>Potential:</p> <p>On or before 06/22/18, the Center Nurse Executive or Designee will review residents' POST and physician orders to ensure that they match and are current to resident wishes. All identified concerns will be immediately addressed.</p>		

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F 578	<p>Continued From page 8</p> <p>would ask whether an advanced directive had been executed.</p> <p>* If an advance directive had been executed and a copy was brought in, a copy would be immediately placed in the clinical record, a copy would be given to the social worker, and nursing staff would be notified.</p> <p>* The advance directive would be reviewed by the interdisciplinary team at each care plan meeting and with a change in condition.</p> <p>* The physician, "in collaboration with designated center staff," would meet with the resident or health care decision maker to review the advance directive upon admission, quarterly, and with a change in condition.</p> <p>The facility's clinical competency validation regarding transcription of orders, dated 9/2012, documented the expected criteria to meet included reviewing the orders and acquiring clarification from the prescriber as necessary.</p> <p>Resident #28 was admitted to the facility on 8/5/16 with multiple diagnoses, including cerebral infarction (stroke) and aphasia (impaired ability to comprehend or express speech).</p> <p>Resident #28's quarterly MDS assessment, dated 5/1/18, documented she had unclear speech, was sometimes understood, and was able to understand others.</p> <p>Resident #28's care plan documented she had a status of DNR. The care plan directed staff to "activate [the] resident's advanced directive as indicated" and to review the advanced directive with the resident and/or her representative quarterly.</p>	F 578	<p>Systemic:</p> <p>On or before 06/22/18, the Center Nurse Executive or Designee will review the POST and the physician's orders to ensure that they match in morning clinical meeting to ensure there are no discrepancies.</p> <p>On or before 06/22/18, the Center Nurse Executive or Designee will educate licensed nursing staff to ensure that they need to review the POST on admission and ensure that the physician order matches.</p> <p>On or before 06/22/2018, the center Licensed Social Worker will review resident choices related to advanced directives including POST and orders at the quarterly care conferences, follow-up will be completed as indicated.</p> <p>QAPI</p> <p>On or before 06/22/2018, the Center Nurse Executive or Designee will audit 3 residents weekly for 4 weeks and monthly for 2 months to ensure that the POST, physician order and care plan match the resident wishes.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 578	Continued From page 9 Resident #28's POST (Physician Orders For Scope of Treatment) documented a status of do not resuscitate and was signed by the resident on 9/29/15. Resident #28's transfer orders/instructions, dated 8/5/16, documented her transfer code status was full resuscitation. Resident #28's physician orders documented "Full Code" (full resuscitation) active as of 8/5/16. Resident #28's nursing assessment from the expanded MDS assessment, dated 8/8/17, documented the advanced directive was reviewed. On 5/15/18 at 3:41 PM, RN #1 said she would have to refer to the care plan in order to review Resident #28's code status. RN #1 said the code status order should be consistent with the advanced directive and she did not know why they were not consistent. On 5/15/18 at 3:53 PM, the CNE said the order for Resident #28's code status was full code. The CNE said the social worker usually involved the nurse when discussing the POST, and the nurse should change it in the computer. The CNE said she would look into it and talk to the social worker to find out what happened. On 5/16/18 at 9:55 AM, the CNE said Resident #28 was hospitalized for pneumonia, and when she returned to the facility the transfer order said full code and was never changed. The CNE said a nurse reviewed the orders and reviewed the	F 578			

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F 578	Continued From page 10 POST with the resident, but never changed the order. The CNE said the order should have been changed in the computer, and she reviewed the POST with the resident and changed the order to DNR.	F 578			
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, policy	F 657		6/22/18	
			Affected:		

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F 657	<p>Continued From page 11</p> <p>review, and resident, family and staff interview, it was determined the facility failed to ensure residents' care plans were revised and updated regarding a catheter that was no longer in place, a transfer pole that was no longer in place, and a urinal that was not being used. This was true for 3 of 14 sampled residents (#21, #24, and #28) whose care plans were reviewed. This created the potential for harm if cares and/or services were not provided appropriately due to inaccurate information on the care plan. Findings include:</p> <p>The facility's policy and procedure regarding person-centered care plans, dated 11/28/16 and revised 3/1/18, documented the care plan would be reviewed and revised by the interdisciplinary team following each assessment and "as needed to reflect the response to care and changing needs and goals."</p> <p>1. Resident #21 was admitted to the facility on 2/14/18 with multiple diagnoses, including neuromuscular dysfunction of the bladder (a disorder bladder caused by neurological damage) and urinary tract infection.</p> <p>Resident #21's care plan documented she required a Foley catheter (a urinary catheter) due to neurogenic bladder.</p> <p>A Progress Note, dated 4/18/18 at 1:16 PM, documented Resident #21 had the Foley catheter removed at the urologist's office and orders were received to replace the Foley if indicated.</p> <p>Resident #21's physician orders documented "monitor Foley (urinary catheter) daily for signs</p>	F 657	<p>On or before 06/22/18, the Center Nurse Executive or designee will review the care plan of resident # 24 and 28 and update for current practices and status of resident. On 5/21/18 resident #21 was discharged home.</p> <p>Potential: On or before 06/22/18, the Center Nurse Executive or Designee will review residents with Foley catheters, assistive devices and ADL care plans to identify any other residents which may be affected. Issues which may be discovered will be corrected by the Center Nurse Executive or Designee on or before 6/22/2018.</p> <p>Systemic: On or before 06/22/18, the Center Nurse Executive or Designee will educate licensed nursing staff regarding the need to update the care plan / physician <input type="checkbox"/>s order /care card and to reflect the resident <input type="checkbox"/>s current status, and care and services provided.</p> <p>On or before 06/22/18, the CNE or Designee will review residents <input type="checkbox"/> care plans for any needed updates or revisions at the customer at risk meeting. Updates to ensure accurate care plans, care cards, and orders to reflect resident status, care and services provided will be completed at that time.</p> <p>QAPI: On or before 06/22/18, the CNE or</p>		

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F 657	<p>Continued From page 12 and symptoms of infection..." was discontinued on 5/1/18.</p> <p>Resident #21's unscheduled MDS assessment, dated 4/24/18, documented a urinary catheter was not in place.</p> <p>On 5/15/18 at 2:22 PM, Resident #21 was observed to not have a urinary catheter, and she said the catheter was discontinued in early April.</p> <p>On 5/17/18 at 12:00 PM, RN #2 said Resident #21 did not have a Foley catheter and the care plan was not accurate and should have been updated.</p> <p>2. Resident #28 was admitted to the facility on 8/5/16 with multiple diagnoses, including cerebral infarction (stroke) and spastic hemiplegia (weakness, paralysis) affecting the left nondominant side.</p> <p>Resident #28's current care plan documented a transfer pole was used to assist with mobility.</p> <p>On 5/14/18 at 3:35 PM, Resident #28 was in her bed and no transfer pole was present in the room.</p> <p>On 5/15/18 at 3:23 PM, CNA #1 said Resident #28 did not have a transfer pole.</p> <p>On 5/15/18 at 3:41 PM, RN #1 said Resident #28 did not have a transfer pole and it was removed long before March 2018.</p> <p>The care plan was not updated to reflect the resident no longer used a transfer pole.</p>	F 657	<p>designee will review 3 residents care plans/care cards weekly for 4 weeks and monthly for 2 months to verify they are reflective of the current resident status and care and services provided. The results of these audits will be reported to the QAPI committee for review monthly X 3 months or until substantial compliance is achieved. The center nurse executive is responsible for monitoring and follow-up.</p>		

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F 657	<p>Continued From page 13</p> <p>3. Resident #24 was admitted to the facility on 1/20/17 with multiple diagnoses, including muscle weakness.</p> <p>Resident #24's quarterly MDS assessment, dated 4/19/18, documented the resident was severely cognitively impaired, required two staff for transfers and toilet use, and was frequently incontinent of bowel and bladder.</p> <p>Resident #24's care plan, dated 2/6/17, directed staff to offer a "urinal/commode as requested/needed" and to "use absorbent products as needed."</p> <p>On 5/14/18 at 1:46 PM and 4:05 PM, a bedside commode was observed in Resident #24's bathroom. A urinal was not observed in the room or the bathroom.</p> <p>On 5/15/18 at 8:45 AM, Resident #24's family member said the resident would sit on the commode and would use it to urinate and/or have bowel movements. Resident #24's family member said the resident used pull-up type briefs during the day and pull-tab type briefs at night so the resident's sleep wasn't interrupted when the resident was incontinent.</p> <p>On 5/15/18 at 3:20 PM, CNA #6 said Resident #24's pull-up brief had just been changed because she was incontinent of urine. CNA #6 said the resident would sometimes use the commode and would even use her call light when she knew she needed to use it.</p> <p>On 5/16/18 at 11:27 AM, CNA #7 said she had</p>	F 657			

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F 657	Continued From page 14 just assisted Resident #24 using the commode and said the resident urinated a little bit. CNA #7 said the resident was placed on the commode before and after meals and prior to laying down. On 5/18/18 at 8:39 AM, RN #4 said staff would assist the resident to use the commode every two hours and before and after meals. She said the resident used pull-up type briefs during the day and pull-tab briefs at night. On 5/18/18 at 9:12 AM, two CNAs were observed assisting the resident to use the commode. CNA #8 said the resident had pull-up type briefs on and the resident had urinated in the commode. On 5/18/18 at 11:59 AM, the MDS Coordinator said the resident did not use a urinal and the care plan should not have documented that. The MDS Coordinator said the care plan did not direct staff when to assist the resident to the commode or the toilet, and it did not direct staff when the resident used the pull-up or pull-tab type briefs.	F 657			
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on review of facility policies, medication	F 684	Affected:	6/22/18	

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F 684	<p>Continued From page 15</p> <p>error investigations, and resident records, and resident, resident family, and staff interviews, it was determined the facility failed to ensure professional standards of practice were followed related to medication management and bowel care. This was true for 1 of 2 of sampled residents (#25) reviewed for bowel and bladder incontinence and 3 of 9 residents (#85, #143, and #144) reviewed for medication management. This failed practice created the potential for harm when orders were not followed regarding bowel management, residents received incorrect dosages of medications, and medications were delayed. Findings include:</p> <p>1. The facility's policy and procedure for standing orders, dated 11/1/07 and revised 11/28/17, documented the following:</p> <ul style="list-style-type: none"> * Standing orders may be used for constipation. * At admission, the standing orders will be reviewed with the physician. * When a standing order is put into effect, the nurse will notify the physician within 24 hours. <p>The facility's Standing Orders Template for constipation documented the following:</p> <ul style="list-style-type: none"> * If no bowel movement in three days, administer Milk of Magnesia 30 ml (milliliters), one dose at bedtime. * If no bowel movement by the next shift, give Dulcolax suppository, one dose. * If no bowel movement within two hours, give a Fleet enema. * If no bowel movement after the Fleet enema, call the physician. 	F 684	<p>Resident #25 was discharged from Payette Center on 06/03/2018. Resident #143 was discharged from Payette Center on 06/02/2018 Resident # 144 was discharged from Payette Center on 08/01/2017. Resident #85 was discharged from Payette Center on 08/31/2017</p> <p>Potential: On or before 6/22/18, a review of resident bowel records for the last 30 days will be completed by the Center Nurse Executive or designee to validate that bowel protocol was implemented and physician orders were followed. Follow-up will be completed as indicated on or before 6/22/2018.</p> <p>On or before 6/22/2018, a review of residents with outside provider appointments completed in the last 30 days will be completed by the Center Nurse Executive or Designee to ensure that paperwork and new orders were received and implemented in a timely manner. Any identified follow-up will be completed by the center nurse executive or designee on or before 6/22/2018</p> <p>On or before 6/22/2018, a MAR review will be completed for any duplicate medication orders by the Center Nurse Executive or Designee. Follow-up will be completed at the time of the review.</p> <p>Systemic On or before 6/22/18, the appointment</p>		

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F 684	<p>Continued From page 16</p> <p>Resident #25 was admitted to the facility on 4/19/18 with multiple diagnoses, including cerebral infarction (stroke) and hypertensive chronic kidney disease.</p> <p>Resident #25's admission MDS assessment, dated 4/26/18, documented she was cognitively intact and was always incontinent of bowel.</p> <p>Resident #25's physician orders, dated 5/3/18, documented the following:</p> <ul style="list-style-type: none"> * Milk of Magnesia 400 mg (milligrams)/5ml give 30 ml as needed for constipation, give at bedtime if no bowel movement in 3 days. * Dulcolax suppository 10 mg insert one suppository as needed for constipation if no result from Milk of Magnesia by next shift. * Fleet enema 7-19 gm (grams)/118 ml insert one dose as needed for constipation if no result from Dulcolax within 2 hours. Call the physician if no results from Fleet enema. <p>Resident #25's May 2018 ADL (Activities of Daily Living) Record documented no bowel movement on May 4 through May 10.</p> <p>The facility's bowel list documented the following:</p> <ul style="list-style-type: none"> * Resident #25 was 48 hours without a bowel movement on 5/5/18 to 5/6/18 and she refused the bowel protocol. * Resident #25 was 72 hours without a bowel movement on 5/6/18 to 5/7/18 and no treatment was documented. * Resident #25 was 96 hours without a bowel movement on 5/7/18 to 5/8/18 and no treatment was documented. 	F 684	<p>book will be reviewed at the morning clinical meeting by Center Nurse Executive or Designee to ensure that paperwork and orders were received for residents with outside appointments. Follow-up will be completed at the time of the review.</p> <p>On or before 6/22/18, the Center Nurse Executive or Designee will educate Licensed Nursing staff as to the importance of evaluating orders for residents who have appointments with outside care providers, and the importance of contacting the resident's attending physician for verification of any orders which may be written by these providers.</p> <p>On or before 6/22/18, the Center Nurse Executive or Designee will educate the licensed nursing staff on the bowel protocol and the importance of following up per the written protocol and document follow up or refusals.</p> <p>On or before 6/22/18, the Center Nurse Executive or Designee will educate the licensed nursing staff on the importance of communicating dose irregularities, and ensuring that duplicate orders are addressed with the attending Physician to verify orders are correct.</p> <p>On or before 06/22/18, the Center Nurse Executive will bring new residents through CAR meeting weekly for 4 weeks and the IDT team will check admitting orders for</p>		

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F 684	<p>Continued From page 17</p> <p>* Resident #25 was 5 days without a bowel movement from 5/8/18 to 5/9/18 and no treatment was documented.</p> <p>*Resident #25 was 6 days without a bowel movement from 5/9/18 to 5/10/18 and Milk of Magnesia was given on 5/10/18.</p> <p>* Resident #25 was 7 days without a bowel movement from 5/10/18 to 5/11/18 and Milk of Magnesia was given.</p> <p>On 5/15/18 at 9:13 AM, Resident #25 said she had experienced some constipation and it was finally taken care of.</p> <p>On 5/17/18 at 10:30 AM, CNA #2 said the ADL book showed Resident # 25 had no bowel movement for 7 days. CNA #2 said the night shift staff routinely tracked residents' bowel movements and gave a bowel list to the nurse.</p> <p>On 5/17/18 at 10:37 AM, RN #2 said Resident #25 did not have bowel movements for awhile. RN #2 said Resident #25 should have been on the bowel list and bowel protocol started.</p> <p>On 5/17/18 at 10:44 AM, The CNE said when a resident does not have a bowel movement it should be put on the bowel list and given to the nurse. The CNE said there was a bowel protocol that starts with Milk of Magnesia then a Dulcolax suppository.</p> <p>On 5/17/18 at 11:54 AM, the CNE said Resident #25 refused Milk of Magnesia on the third day of no bowel movement. The CNE said Milk of Magnesia was given on day 6 and again on day 7, and staff did not follow the protocol.</p>	F 684	<p>accuracy and presence of bowel care protocol.</p> <p>QAPI Beginning 06/22/18, the Center Nurse Executive or Designee will audit admission orders for 3 residents, weekly for 4 weeks and monthly for 2 months, for correctly placed admission orders, questionable medications, and timely/appropriate orders from medical doctors other than the attending physician.</p> <p>On or before 06/22/18, the Center Nurse Executive or Designee will review results from Quality of Care audits including bowel care review and order reviews, weekly X4 weeks and then monthly X2 months. Results of these audits will be presented by the Center Nurse Executive in the monthly QAPI meeting for discussion and recommendations X3 months or until substantial compliance is achieved. The Center Nurse Executive is responsible for monitoring and follow-up.</p>		

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F 684	<p>Continued From page 18</p> <p>2. The facility's policy and procedure for medication administration of oral medications, dated 1/1/04, directed staff to verify the medication order on the MAR with the medication label for the correct patient, drug, dose, route, and time. This policy was not followed. Examples include:</p> <p>a. Resident #143 was admitted to the facility on 4/23/18 with multiple diagnoses, including generalized idiopathic epilepsy and epileptic syndromes.</p> <p>Resident #143's admission MDS assessment, dated 5/4/18, documented he had short term and long term memory problems and a moderate cognitive impairment.</p> <p>Resident #143's April 2018 physician orders documented the following:</p> <ul style="list-style-type: none"> * Depakote tablet (anti-seizure medication) delayed release 500 mg, 3 tablets twice a day. * Valproate sodium solution (anti-seizure medication) 250 mg/5 ml, 20 ml three times a day. <p>The Nursing 2018 Drug Handbook documented Depakote is a brand name and valproate sodium is the generic name for the same medication.</p> <p>Resident #143's care plan documented the following interventions related to seizures:</p> <ul style="list-style-type: none"> * "Correct medication orders and draw [drug] level to ensure safe level" was initiated on 5/2/18. * Medicate as ordered and monitor for effectiveness as well as side effects..." was 	F 684			

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NAME OF PROVIDER OR SUPPLIER PAYETTE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1019 THIRD AVENUE SOUTH PAYETTE, ID 83661		
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F 684	<p>Continued From page 19 initiated on 5/1/18.</p> <p>Resident #143's April 2018 and May 2018 MARs documented the following:</p> <ul style="list-style-type: none"> * Depakote tablet delayed release 500 mg 3 tablets twice a day was administered on 4/23/18-5/1/18. * Valproate sodium 250 mg/5 ml 20 ml three times a day was administered 4/23/18-5/16/18. <p>A Progress Note, dated 5/1/18 at 12:01 PM, documented a medication error occurred regarding Depakote ER (extended release) and valproic acid on 4/23/18 in the afternoon.</p> <p>A Medication Error Investigation, dated 5/1/18 at 12:00 AM, documented Resident #143 was admitted to the facility with all of his medications. The Depakote tablets were to be discontinued and valproic acid was to be started (the liquid form). Both medications were given to Resident #143 after he was admitted to the facility. The physician and hospice nurse were notified, and orders were received to discontinue the Depakote tablets and draw a valproic acid level.</p> <p>A physician's order, dated 5/1/18 at 4:13 pm, documented Resident #143's Depakote tablet order was discontinued.</p> <p>A lab report, dated 5/1/18 at 2:30 pm, documented Resident #143's valproic acid level was 131. The desired range for valproic acid was 50-100. A physician's order was written on the lab report that directed staff to hold the valproic acid for 24 hours then resume the medication.</p>	F 684			

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

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F 684	<p>Continued From page 20</p> <p>On 5/14/18 at 11:51 AM, Resident #143's family member stated the resident had two anti-seizure medications after admission, one liquid and one pill form that were sent with him from the previous facility. Resident #143's family member said both medications were given for a short time and he was more lethargic.</p> <p>On 5/17/18 at 1:00 PM, RN #3 said he was aware of Resident #143 receiving duplicate medication and a valproic acid level was drawn, which was a little high. RN #3 stated the medication was held for a day and then resumed, and he only administered the liquid form of the medication because the resident would not swallow pills.</p> <p>On 5/17/18 at 1:06 PM, the CNE said there was a medication error for Resident #143. The CNE stated a nurse entered the order for Depakote and then entered an order for valproic acid, not realizing they were the same medication. Another nurse noticed the duplicate medication and changed the order.</p> <p>b. Resident #144 was admitted to the facility on 7/12/17 with multiple diagnoses, including atrial fibrillation and history of transient ischemic attack and cerebral infarction (stroke) without residual deficits.</p> <p>Resident #144's discharge MDS assessment, dated 8/1/17, documented she was cognitively intact, and she received anti-anxiety medication on seven out of seven days.</p> <p>Resident #144's July 2017 physician orders documented an order for Xanax (anti-anxiety</p>	F 684			

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F 684	<p>Continued From page 21 medication) tablet 0.25 mg every 24 hours as needed.</p> <p>A Medication Error Investigation, dated 7/9/17 at 8:00 AM, documented Resident #144 was given an extra dose of anti-anxiety medication on 7/8/17. The resident's family member was notified, and the resident was evaluated in the emergency room and was diagnosed with low sodium, which was not related to the medication error.</p> <p>An Accident/Incident Witness Interview Tool, dated 7/10/17, documented Resident #144 was given an extra dose of anti-anxiety medication on 7/8/17 and a medication error was made.</p> <p>On 5/18/18 at 10:53 AM, the CNE said there was a medication error for Resident #144 when the nurse administered a dose of anti-anxiety medication without looking up whether it had already been administered, so the resident received a second dose.</p> <p>c. Resident #85 was admitted to the facility on 11/29/16 with multiple diagnoses, including hypertension.</p> <p>The resident sign out sheet documented Resident #85 signed herself out of the facility on 6/28/17 at 10:15 AM and returned at 6:00 PM.</p> <p>Resident #85's Family Nurse Practitioner (FNP) office visit note documented the resident was seen in the FNP's office on 6/28/17 at 10:40 AM.</p> <p>Resident #85's FNP orders, dated 6/28/17, documented on a facility physician's order form to</p>	F 684			

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F 684	<p>Continued From page 22</p> <p>discontinue Losartan (to treat high blood pressure) 50 mg and start Losartan 25 mg, start Prednisone (anti-inflammatory) 20 mg two tablets a day for 5 days, and start Azithromycin (antibiotic) 250 mg 2 tablets on day 1, then 1 tablet on days 2 through 4. The form also documented the resident's name and date of birth along with a facility stamp that indicated the order was received. RN #3 documented on the form that the order was processed by the facility on 7/6/17.</p> <p>A FNP's Prescription form, dated 6/28/17, documented Resident #85's orders for Losartan 25 mg, Prednisone 20 mg, and Azithromycin 250 mg. The prescription documented a handwritten note, "fax to [facility name]."</p> <p>Resident #85's June 2017 MAR document the resident received Losartan 50 mg for 30 out of 30 days and did not receive Prednisone or Azithromycin.</p> <p>Resident #85's July 2017 physician's order recapitulation documented an order for Losartan 50 mg and did not document orders for Prednisone or Azithromycin</p> <p>Resident #85's July 2017 MAR documented the resident received:</p> <ul style="list-style-type: none"> * Losartan 50 mg for hypertension from 7/1/17 to 7/5/17 and then the order was discontinued. * Losartan 25 mg for hypertension from 7/6/17 to 7/31/17. * Prednisone 20 mg, 2 tablets for 5 days, for a facial rash from 7/6/17 to 7/10/17. * Azithromycin 250 mg, 2 tablets for 1 day, for a facial rash on 7/5/17. 	F 684			

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F 684	<p>Continued From page 23</p> <p>* Azithromycin 250 mg, 1 tablet for a facial rash from 7/6/17 to 7/8/17.</p> <p>Resident #85's Progress notes from 6/28/17 through 7/6/17 did not document new orders by the FNP or that she was seen by the FNP.</p> <p>On 5/17/18 at 2:40 PM, Resident #85 said she did not think some of her medications ordered by her FNP were filled in a timely manner.</p> <p>On 5/17/18 at 11:39 AM and 5/18/18 at 3:46 PM, RN #4 said when a resident left the facility to see a provider, staff sent a facility physician's order form with the resident, and then the nurse would receive the order form when the resident returned. Any new orders were processed by the nurse. RN #4 said most of the time the providers also faxed the new orders to the facility and providers generally called to make sure the facility received the orders. RN #4 said she remembered at least one time when Resident #85 saw her FNP and brought back orders without telling staff that she had gone to the appointment or that she had new orders until several days later. RN #4 said she did not remember documenting this incident in the progress notes.</p> <p>On 5/17/18 at 1:36 PM and on 5/18/18 at 3:42 PM, the Medical Records representative (MR) said she was not sure how the facility received the 6/28/17 FNP notes, order form, or the prescription. She said if those had been faxed then there should have been a fax header on top of the page showing the date and time they were received, but it was not found on those documents. The MR said she was not sure why</p>	F 684			

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F 684	Continued From page 24 the prescription documented the handwritten note, "fax to [facility name]" and said she had to assume the provider's office wrote that. She said she would have to assume that the form was returned when the resident came back to the facility. The MR said faxed orders were sent to the fax machines in the medication rooms and only the nurses had access to those room because they were the ones who processed the orders. On 5/17/18 at 1:48 PM and 5/18/18 at 4:27 PM, the CNE said when residents went out of the facility to other provider appointments, the facility would send a facility physician's order form with the resident or with the van driver if they went via the facility van. The CNE said she could not determine when the facility received Resident #85's facility physician's order form and was not sure why the orders were processed several days after the order date. On 5/18/18 at 3:25 PM, the FNP's Office Manager said their records indicated the 6/28/17 physician's orders for Resident #85 were faxed to the facility on 6/28/17.	F 684			
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the	F 727		6/22/18	

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F 727	<p>Continued From page 25 director of nursing on a full time basis.</p> <p>§483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure an RN was on duty 8 hours a day 7 days a week to provide care and treatment to the residents. This was true for 1 of the 21 days reviewed. This affected 10 of 10 (#3, #5, #6, #18, #19, #24, #25 #28, #29, and #143) sample residents residing in the facility and had the potential to affect the other 26 residents residing in the facility. This created the potential for harm if residents' nursing needs went unmet. Findings include:</p> <p>The facility's Three-Week Nursing Schedule between 4/22/18 and 5/2/18 documented there was no RN coverage on 4/28/18.</p> <p>The facility's daily staffing sheet for 4/28/18 documented there was no RN coverage for that day.</p> <p>This created the potential for the routine and emergency nursing needs of Residents #3, #5, #6, #18, #19, #24, #25, #28, #29, and #143, as well as, the other 26 residing in the facility, to go unmet.</p> <p>On 5/16/18 at 10:04 AM, the CNE said there was no RN coverage for 4/28/18. She said one of the night RNs was being switched to days and the coverage was missed.</p>	F 727	<p>Affected: Residents #3, 5, 6, 18, 19, 24, 25, 28 and 29 will be assessed by the center nurse or designee, on or before 06/22/2018, for any adverse effects related to lack of RN coverage.</p> <p>Potential: On 05/17/2018, a review of RN coverage for the last 30 days was completed to verify RN coverage was provided with no additional concerns noted.</p> <p>Systemic: On or before 06/22/2018, any registered nurse calling in as absent will be referred to the center nurse executive or designee to ensure that RN coverage is maintained.</p> <p>Beginning 06/01/2018, the monthly nursing schedule will be approved by the Center nurse Executive or designee to ensure adequate RN coverage.</p> <p>QAPI: On or before 06/22/2018, Licensed Nurse Schedules will be reviewed by the Center Nurse Executive, weekly for four weeks then monthly for two months, to insure</p>		

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F 727	Continued From page 26 On 5/16/18 at 10:57 AM, the Business Office Manager said she had compared the daily assignment sheet and the actual worked schedule and said there was no RN scheduled for 4/28/18.	F 727	RN staffing is in accordance with regulations. Results will be presented in the monthly QAPI meeting X3 months for discussion and recommendations and corrective action as necessary until substantial compliance is achieved. The Center Nurse Executive Unit manager will monitor for compliance.		
F 804 SS=F	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(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, record review, resident interviews, resident group interview, test tray evaluation and staff interview, it was determined the facility failed to serve palatable food and drinks. This affected 5 of 5 (#2, #3, #12, #18 and #84) residents in the group interview, 2 of 14 (#3 and #85) sampled residents, and 2 (#21 and #29) random residents and had the potential to affect all residents who dined in the facility. This failed practice created the potential to negatively affect residents' nutritional status and psychosocial well-being related to unpalatable food. Findings include: The facility's Spring/Summer 2018 menu	F 804	Affected: On or before 06/22/18, Residents #2, #3, #12, #18, #84, #85, #21, and #29 will be assessed by the RD and FSD as to food variety, appearance, taste, and temperature concerns. Issues found will be incorporated into our corrective actions and QAPI projects. On 06/16/18, the Food Service Director, purchased crystal light beverage mixes in five additional flavors to insure adequate supply of sugar free beverages and provide for resident choice. Potential:	6/22/18	

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F 804	<p>Continued From page 27</p> <p>documented the facility served fish as the main dish four times in a three-week period.</p> <p>On 5/14/18 at 10:25 AM, Resident #3 said the food was "lousy."</p> <p>On 5/14/18 at 10:41 AM, Resident #21 said she was not satisfied with the food and there were too many carbohydrates.</p> <p>On 5/14/18 at 12:23 PM and 5/15/18 at 12:51 PM, Resident #29 said the food lacked taste and quality, and the food looked and tasted very institutional.</p> <p>On 5/15/18 at 1:34 PM, during the Resident group interview, Residents #2, #3, #12, #18 and #84 said the food, especially the fish, was not worth eating. They said the food lacked flavor and temperatures were not hot enough. Residents #2, #12, and #18 said the only sugar-free drink was lemonade and it did not taste good. Resident #2 said ice tea was also available to those who drank tea, but he was tired of it. Residents #2, #3, #12, and #18 said all of these issues had been discussed in previous Resident Council meetings, but the facility had not done enough to look into these concerns. The residents also said the DM would tell residents that she would let "corporate" know about the concerns, but then nothing would be done.</p> <p>On 5/16/18 at 2:05 PM, Resident #18 said the pizza was cold for lunch that day.</p> <p>On 5/17/18 at 8:27 AM, a breakfast meal test tray was evaluated by two surveyors with the DM</p>	F 804	<p>A review of meals for the last three weeks will be completed by the center ED or Designee for variety, temperature, palatability, and appearance on or before 6/22/2018. Follow-up including modifications to menu, new meal trays, or Dietitian review will be completed as indicated.</p> <p>On or before 06/22/18 residents will be assessed by the Registered Dietitian and Food Service Director as to food variety, appearance, taste, and temperature concerns. Issues found will be incorporated into our corrective actions and QAPI projects.</p> <p>Systemic: On or before 06/22/18, in order to provide palatable food at proper temperatures, Food Service staff will receive training on: the importance of adherence to the established recipes, food preparation, steam table temperatures, and tray line operation.</p> <p>On or before 06/22/18, the Food Service Director will implement a daily test tray for 4 weeks. The test tray will review tray line and delivery temperature, appearance, taste, and menu adherence. After the 4 week daily tests are completed, the Food Service Director will complete 3 test trays per week at Breakfast, Lunch, and Dinner on alternate days.</p> <p>On or before 06/22/2018, the Registered Dietitian will prepare and implement</p>		

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F 804	<p>Continued From page 28</p> <p>present. One pancake had a temperature of 104-degrees F (Fahrenheit) and the other pancake was 117-degrees F. The DM said the outside of the pancake was "a little hard" and cold. The breakfast ham had a temperature of 122 F and the DM said the ham was a little cold and tough. The oatmeal had a temperature of 128 F and the DM said the oatmeal was cold.</p> <p>On 5/17/18 at 10:21 AM, the DM with the RD present said she was aware that several residents did not like the fish served in the facility and said the facility offered several alternative items. The DM said she was not aware of the 4/17/18 Resident Council minutes about the sugar-free options request and she had just heard the residents did not like the sugar-free lemonade about two or three weeks ago. The DM said the sugar-free pink lemonade was the only option offered through the facility's order form and she called her corporate contact about two or three weeks ago to see about other options, but she had not heard back from the corporate contact and had not contacted the individual again. The RD said the facility did offer tea and sugar-free hot cocoa.</p> <p>On 5/17/18 at 3:11 PM, Resident #85 said she experienced a beneficial weight loss while in the facility because the food was "awful" and she chose not to eat much.</p>	F 804	<p>alternate menu choices for vegetables, lean protein, and garden salad. Menus will be adjusted by the Food Services Director to include these items. Future menu cycles will be reviewed by the RD to ensure inclusion of these alternate menu choices and adjust for resident choice items.</p> <p>On 05/01/18, members of the facility management team were assigned to serve, on a rotational basis, as Food Servicer Monitors at each meal. On or before 06/22/2018, Food Service Monitors will make note of all food-related concerns reported by residents during meals. They will follow-up immediately to correct issues in real time. In order to provide food at proper temperatures, they will monitor delivery times from cart to meal presentation in the dining room and resident rooms, monitor and adjust as necessary the number of staff serving meals to residents in rooms, and monitor the number of cart stopping points in the hallways as the meal service proceeds.</p> <p>QAPI: On or before 06/22/2018, results of test trays, Dining Monitor reports, resident concerns, and corrective actions will be reviewed in the Monthly QAPI meeting. Corrective projects will be implemented as necessary.</p> <p>Beginning 6/22/2018, the Center Executive Director or designee will audit 5 resident meals to ensure that meals are</p>		

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F 804	Continued From page 29	F 804	<p>palatable including temperature, texture, and flavor. Weekly X 4 weeks and then monthly X 2 months.</p> <p>Beginning 6/22/2018, the monthly menu will be presented at the resident council meeting for review and approval by the Food Services Director or Designee to ensure variety and regional preferences are met.</p> <p>The results of these audits and Resident Council review will be reported to the center QAPI committee for review monthly X3 months or until substantial compliance is achieved. The center executive director is responsible for compliance.</p> <p>The Center Executive Director will monitor Compliance</p>		

Bureau of Facility Standards

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C 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the State licensure survey of your facility from May 14, 2018 through May 18, 2018.</p> <p>The surveyors conducting the survey were: Brad Perry, LSW, Team Coordinator Cecilia Stockdill, 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:</p> <p>On 5/14/18 at 8:18 AM, the Administrator said 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	Waiver previously applied for and granted by State	6/22/18

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Electronically Signed

TITLE

(X6) DATE
06/07/18



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
LICENSING & CERTIFICATION
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November 2, 2018

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

Provider #: 135015

Dear Mr. Hayes:

On **May 18, 2018**, an unannounced on-site complaint survey was conducted at Payette Center. The complaint was investigated during an unannounced on-site recertification survey conducted May 14, 2018 to May 18, 2018. During the investigation resident records were reviewed, observations were conducted, medication error reports were reviewed, policies were reviewed, staff were interviewed, and residents were interviewed.

The complaint allegation, findings and conclusions are as follows:

Complaint #ID00007574

ALLEGATION #1: Residents received inappropriate dosages of medication and duplicate medications.

FINDINGS #1:

The complaint was investigated during an unannounced on-site recertification survey conducted May 14, 2018 to May 18, 2018. During the investigation resident records were reviewed, observations were conducted, medication error reports were reviewed, policies were reviewed, staff were interviewed, and residents were interviewed.

Three nurses were observed while administering medications by different routes (oral, intravenous, inhaled, injectable, intranasal, eye drops). Two nurses were interviewed.

One medication error report documented a resident received a second dose of anti-anxiety medication at bedtime when it had already been administered. Another medication error report documented the resident received the same medication simultaneously both in pill form and in liquid form. Two residents' clinical records documented a medication error occurred, resulting in the resident receiving a double dose of medication.

During an interview, a nurse stated the medication error occurred for one resident when the resident received two doses of anti-anxiety medication because the nurse did not look to see whether the medication was already administered.

A second resident who was diagnosed with epilepsy received the generic and brand name form of the same medication. A Medication Error Investigation, dated 5/1/18, documented the resident was admitted to the facility with all of his medications. The Depakote tablets (brand name) were to be discontinued and valproic acid (generic name) was to be started (the liquid form). Both medications were given to the resident after he was admitted to the facility. The physician was notified, and orders were received to discontinue the Depakote tablets and draw a valproic acid level to ensure it was within a therapeutic level.

On 5/17/18, a Registered Nurse (RN) said he was aware the resident received duplicate medications and a valproic acid level was drawn, which was a little high. The RN stated the medication was held for a day and then resumed, and he only administered the liquid form of the medication because the resident would not swallow pills.

On 5/17/18, the Center Nurse Executive (CNE) said there was a medication error for the resident. The CNE stated a nurse entered the order for Depakote and then entered an order for valproic acid, not realizing they were the same medication. Another nurse noticed the duplicate medication and changed the order.

Based on the investigative findings, the allegation was substantiated and the facility was cited at F684 for the failure to follow professional standards of practice related to medication administration and management.

ALLEGATION #2:

Residents were prescribed medication against their wishes and family member's wishes.

FINDINGS #2:

The clinical records of 6 residents who received psychotropic medications were reviewed. One nurse was interviewed.

Six of six residents' clinical records documented an informed consent for psychotropic medication was signed by the resident or their responsible party. During an interview, one nurse stated a consent was obtained for use of psychotropic medications, and the consent was documented in each resident's record. One resident's record documented the resident stated she was ready to start anti-depressant medication, and the resident and her family member agreed to change from one anti-depressant medication to a different anti-depressant.

The allegation was not substantiated related to lack of evidence the residents were prescribed medications against their wishes and/or their family member's wishes.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

Residents were denied visits by the physician.

FINDINGS #3:

Eight residents and 1 nurse were interviewed. The record of 6 residents were reviewed.

The 8 residents interviewed did not express concerns regarding physician visits. During an interview, a nurse stated if a resident wanted to see the physician during his rounds then the resident would be seen, and she was not aware of any instance when a resident was not seen by the physician when they requested.

One resident's record documented she was seen by a medical provider every 1 to 2 months, including multiple times upon her request.

The allegation could not be substantiated due to lack of evidence the facility denied visits from a resident's physician.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

Residents were physically abused by facility staff.

FINDINGS #4:

Four staff members were interviewed regarding identifying and appropriately intervening if abuse occurred between a staff member and a resident. Five residents and 1 family member were also interviewed. Facility grievances were reviewed and facility staff were observed providing care and interacting with residents in the facility throughout the survey.

Four of the staff members interviewed were able to identify appropriate interventions if they should witness abuse occurring between a staff member and a resident. Five residents and 1 family member who were interviewed expressed no concerns regarding physical abuse and stated they had not witnessed staff members mistreat residents. Facility staff provided care and interacted appropriately with residents during observations. A review of the facility's grievances did not include concerns regarding staff physically mistreating or abusing residents.

The record of 1 resident documented the resident requested to see the physician when he was making rounds. The resident stated she was told no and was pushed back into her room by a nurse. The facility's investigation documented the resident identified ancillary staff, who did not go on physician rounds and who said they did not have contact with the resident on the day the incident occurred. The facility's investigation documented when the resident was presented with photographs of nurses who accompanied the physician on rounds, the resident said none of those nurses were involved.

During an interview 1 nurse said if a resident requested to see the physician they were seen. The nurse said she was not aware of an instance when a resident requested to see the physician and was not seen, and she was not aware of any instances of physical abuse between staff and residents.

The allegation could not be substantiated due to lack of evidence residents were physically abused by facility staff.

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.

James Hayes, Administrator
November 2, 2018
Page 5 of 5

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,

A handwritten signature in black ink, appearing to read "Laura Thompson".

Laura Thompson, RN, Supervisor
Long Term Care Program

LT/lj



IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

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February 20, 2019

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

Provider #: 135015

Dear Mr. Hayes:

On **May 18, 2018**, an unannounced on-site complaint survey was conducted at Payette Center. The complaint was investigated during the facility's on-site Recertification and State Licensure survey conducted May 14, 2018 through May 18, 2018.

A meal test tray was evaluated. Several residents were observed for signs and symptoms of pain and upper respiratory infections.

The clinical records of 16 residents were reviewed for Quality of Care issues. The facility's Grievance file was reviewed, as well as its Incidents and Accident reports. The Resident Council minutes and the facility's Admission Agreement were reviewed.

Several residents, residents' family members, several CNAs, and several nurses were interviewed regarding various Quality of Care and Quality of Life issues. The Business Office Manager of a local Family Nurse Practitioner was interviewed. The Social Worker, the Medical Records representative, the Medical Director, the Dietary Manager, as well as the Center Nurse Executive and Administrator were interviewed regarding various issues.

The complaint allegations, findings and conclusions are as follows:

Complaint #ID00007569

ALLEGATION #1:

A resident had lost weight while in the facility.

FINDINGS #1:

A sample meal was evaluated for palatability and it was found to be cold and unpalatable.

Four residents' clinical records were reviewed for weight loss and although one of the resident's records documented weight loss, the resident's weight loss was monitored appropriately. Resident Council minutes documented concerns with food, including the food being cold, flavorless, and the meat was tough.

Several residents said the food lacked flavor and was often cold. A discharged resident said he/she lost weight because the food was not flavorful and often refused to eat it, however the weight loss was beneficial for him/her. The Dietary Manager said the sample meal was cold, the ham was tough and the pancakes were hard.

Based on the investigative above information, it was determined the allegation was substantiated.

A deficiency was cited at F804 as it relates to the failure of the facility to serve palatable food. Refer to the federal recertification and complaint survey report dated May 18, 2018.

CONCLUSIONS:

Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #2:

A resident's abdominal pain and upper respiratory infection were not managed.

FINDINGS #2:

Several residents were observed for abdominal pain and upper respiratory infections and residents were observed to receive appropriate treatment and care.

The clinical records of six residents were reviewed for pain management and infections and no concerns were identified.

Several residents said their pain was managed and had no concerns regarding infections. Several residents' family members said they had no concerns regarding pain management or infections. Several CNAs and nurses said when residents expressed pain or showed signs and symptoms of pain and/or infections, the residents were evaluated appropriately. The Center Nurse Executive said residents were evaluated appropriately.

Based on the investigative findings, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

Residents were only allowed to choose the facility's Medical Director as their primary healthcare provider.

FINDINGS #3:

The admission records of three residents were reviewed and all of the residents' records documented that they had chosen the Medical Director as their primary care physician. The facility's Admission Agreement documented residents had a choice of medical providers. The facility's Grievance file was reviewed and there were no concerns regarding choice of providers.

Several residents said they had no concerns regarding their choice of physician and could leave the facility to see other providers and specialists. A discharged resident said he/she said he/she saw both the Medical Director and their Family Nurse Practitioner. Several nurses said residents were able to see other healthcare providers. The Social Worker said she assisted with new admissions and said residents had a choice of physicians, but most residents chose the facility's Medical Director since he and his staff would come to the facility to see the residents and were available 24 hours a day. The Center Nurse Executive said residents have chosen other providers and said good communication between the other providers and the facility was critical to make sure the residents' care was managed appropriately. The Administrator said residents had the right to choose other primary healthcare providers. The Medical Director said he had no problem if residents wanted to see another provider.

Based on the investigative above information, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4:

Residents' blood work was ordered by the facility's Medical Director, even after it had been completed by another healthcare provider.

FINDINGS #4:

The clinical records of three residents were reviewed for blood lab work and duplicate blood work was not identified as a concern.

Several residents voiced no concerns regarding duplicate blood lab work. A discharged resident said he/she had not had duplicate blood work done. Several nurses said the facility worked hard to make sure duplicate tests were not done unnecessarily. The Center Nurse Executive said the facility staff worked hard to make sure residents received the appropriate care and treatment and that provider orders did not duplicate each other.

Based on the investigative findings, it was determined the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

Residents' medications were not filled when their primary healthcare provider had written orders for them.

FINDINGS #5:

The clinical records of seven residents were reviewed for medication. For one of the residents, three medications were filled later than the Family Nurse Practitioner's order date.

Several residents said they had no concerns of not receiving their medications. A discharged resident said he/she did not receive his/her medications in a timely manner. The Business Office Manager of a local Family Nurse Practitioner's office said orders were faxed to the facility for one of the residents on the day the orders were signed. The Medical Records representative said she could not be certain how the orders were missed. The Center Nurse Executive said there was a delay on a resident's orders from a Family Nurse Practitioner, the resident received the medications late, and did not know why the orders were missed.

James Hayes, Administrator
February 20, 2019
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Based on the investigative above information, it was determined the allegation was substantiated.

A deficiency was cited at F684 as it relates to the failure of the facility to provide medication in a timely manner. Refer to the federal recertification and complaint survey report dated May 18, 2018.

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 any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,

A handwritten signature in cursive script that reads "Belinda Day".

Belinda Day, RN, Supervisor
Long Term Care Program

BD/lj