

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

PRINTED: 05/21/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135015</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/25/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH</b> <b>PAYETTE, ID 83661</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p><b>INITIAL COMMENTS</b></p> <p>A complaint survey was conducted at the facility from October 24, 2018 through October 25, 2018. The facility was found in substantial compliance with 42 CFR 483.</p> <p>The surveyors conducting the survey were:</p> <p>Jenny Walker, RN Team Leader Susette Mace, RN</p>	F 000			

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

TITLE

(X6) DATE

Electronically Signed

11/07/2018

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.



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

BRAD LITTLE – Governor  
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR  
LICENSING & CERTIFICATION  
DEBBY RANSOM, R.N., R.H.I.T – Chief  
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May 17, 2019

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

Provider #: 135015

Dear Mr. Hayes:

On **October 24, 2018** through **October 25, 2018**, an unannounced on-site complaint survey was conducted at Payette Center. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007879**

Allegation #1:

The facility refused to transfer a resident to the hospital and the family had to call an ambulance to take them.

Findings #1:

During the survey eight resident records were reviewed, observations were conducted, and residents and family were interviewed.

Resident interviews were conducted to determine if they were allowed their choice of physician, and if they had any delay in treatment. All resident interviews revealed no issues with the facility services and treatment. Family interview of a current resident's family revealed no issues to report.

One resident's record included documentation the responsible party for the resident signed the transfer of physician services to the facility Medical Director to provide care upon admission on 6/9/18.

The resident's record included a Progress Note which documented the resident ' s daughter approached a nurse at 11:25 AM and stated she wanted the resident transferred to ER for evaluation for dehydration, mental status change, and an x-ray. The staff prepared the paperwork for transfer, a transport arrangement was made for the resident at 11:45 AM and the resident's transport arrived at 11:50 AM.

Based on investigative findings the allegation could not be substantiated.

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

#### Allegation #2:

The facility failed to follow up on treatment for a Urinary Tract Infection (UTI) in a timely manner.

#### Findings #2:

During the survey five resident records were reviewed for infections and medications, six residents were reviewed for changes in bladder function, and observations were conducted.

One resident was admitted to the facility with a chronic UTI and urinary incontinence. The resident received antibiotic therapy. Review of the medication administration record (MAR) documented the admission order was completed and all antibiotics were administered. The resident was also on a prophylaxis antibiotic to prevent reoccurrence of UTI's, which was also administered as ordered.

The resident's physician was notified of a preliminary laboratory report related to a urine Culture & Sensitivity, but chose to wait on the full Culture & Sensitivity report to ensure the resident was started on the antibiotic medication that was effective for the specific organism. Upon receipt of the test results the physician prescribed the antibiotic specific to the organism identified for treatment of the UTI for the resident. Review of the MAR revealed staff provided the medication as ordered.

Observation of incontinence care of residents revealed no issue with the provision of care and no issue with infection control. General observation during the survey revealed no identified infection control issues by staff providing resident care.

James Hayes, Administrator  
May 17, 2019  
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There was insufficient evidence to establish that the facility acted inappropriately in response to the subject of the allegation and no deficiencies were written.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

Allegation #3:

Staff were rough when assisting residents which resulted in bruising.

Findings #3:

During the survey eight resident records were reviewed, facility incident reports were reviewed, facility grievances were reviewed, staff personnel files were reviewed, and observations were conducted.

Personnel files for staff were reviewed. The facility did background checks and provided abuse training which was appropriate to all staff. There was no documentation in the personnel files of substantiated abuse by staff.

Review of facility incident reports from June 2018 through October 2018 did not include reports of rough treatment or abuse by staff to residents. Review of additional incident reports involving a bruise on a resident documented the facility investigated and concluded bruising was not related to abuse or neglect by staff. Review of grievances for the facility for the past 6 months did not include documentation of complaints of bruising due to rough treatment by staff.

One resident was observed while being transferred by two staff using a mechanical lift. There were no concerns identified during the observation.

Based on investigative findings 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.

James Hayes, Administrator  
May 17, 2019  
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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



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June 19, 2019

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

Provider #: 135015

Dear Mr. Hayes:

On **October 24, 2018** through **October 25, 2018**, an unannounced on-site complaint survey was conducted at Payette Center. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007924**

**ALLEGATION #1:**

The facility did not notify the family for the resident's change of condition.

**FINDINGS #1:**

During the investigation eight residents were observed and their records were reviewed for Quality of Care and Resident Rights. Residents and staff were interviewed.

Eight residents' clinical records were reviewed for changes of condition with family notification of changes. No concerns were identified.

Six residents were interviewed regarding family notification with a change of condition. No concerns were identified. Three family members of the six residents were interviewed regarding notification of change of condition and stated there were no concerns.

James Hayes, Administrator  
June 19, 2019  
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Nurses were interviewed and stated when the resident had a change of medication or change of condition, the family was notified of the change of condition.

Based on the investigative findings the allegation could not substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2:

The resident had delay in treatment for a UTI (Urinary Tract Infection).

FINDINGS #2:

Five resident records were reviewed for UTI.

One resident record documented they had symptoms of a UTI, the facility obtained a urine specimen and the results were positive two days later with the culture and sensitivity susceptibility. The physician was notified of the abnormal urinalysis and the resident was started on antibiotics.

Based on the investigative findings the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3:

Residents were not receiving assistance with meals and nutrition.

FINDINGS #3:

Residents were observed during meal times, residents were interviewed, and three resident records were reviewed.

Three residents were observed receiving assistance with their meals by staff. No concerns were identified.

Three residents were interviewed and no concerns were identified regarding receiving assistance with meals.

One resident's record, admitted August 2018, documented they required extensive assistance of one person for meals. The resident's record documented intravenous (IV) fluids were initiated for 24 hours prior to the resident discharging to the hospital. The facility identified concerns with the resident's decreased intake and change of condition and interventions were provided for nutrition.

Based on the investigative findings the allegation could not be substantiated.

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #4:

The facility's staff were not providing incontinence care to the residents.

#### FINDINGS #4:

Six resident records were reviewed for incontinence care, three residents were observed during incontinence care, and staff were interviewed.

Three residents were observed receiving incontinence care and no concerns were identified.

One resident's record documented they were admitted with a urinary catheter. The resident's record documented the resident was incontinent and declined to have staff assist the resident to the bedside commode or the bathroom. The resident's record documented the resident preferred to be incontinent in the adult briefs.

Certified nursing assistants (CNAs) and nurses were interviewed and stated some residents prefer to be incontinent instead of receiving assistance to the bathroom. They stated when residents were incontinent they checked and changed the resident every two hours and as needed.

Based on the investigative findings the allegation could not be substantiated.

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5:

The facility's staff were not repositioning residents in a timely manner.

FINDINGS #5:

Residents were observed during care by staff, four residents were interviewed, staff were interviewed, and five resident records were reviewed.

Four residents were observed for repositioning by the staff and no concerns were identified. The four residents were interviewed regarding repositioning and they stated they liked how much the CNAs made sure they were repositioned every two hours or as needed to be comfortable.

CNAs were interviewed and stated they were responsible to assure residents were repositioned every two hours and as needed to prevent skin breakdown and to make sure the residents were comfortable and in a safe position. The CNAs stated when a resident declined to be repositioned they asked if the resident was in pain and notified the nurse.

Nurses were interviewed and stated the CNAs were very good about repositioning the residents every two hours. If the resident declined repositioning, the nurses assessed the resident for pain and administered pain medications if needed, then repositioned them. When residents still declined to be repositioned, they educated the resident for the risk versus the benefits and also notified the therapy department and the physician.

One resident's record documented the resident's refusal to be repositioned. The nurses assessed the resident for pain, the need for pain management, and therapy was involved. No concerns were identified.

Based on the investigative findings the allegation could not be substantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6:

Residents were not being offered water.

James Hayes, Administrator  
June 19, 2019  
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FINDINGS #6:

Residents were observed for hydration, staff were observed for assistance with hydration, and eight resident records were reviewed.

Six residents were observed with water within reach at their bedside. Staff were observed assisting residents with water and also offering water to residents. No concerns were identified.

One resident's clinical record documented the resident had a change of condition and IV fluids were initiated. The facility identified the change of condition and implemented appropriate interventions. No concerns were identified.

Based on the investigative findings 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.

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,



Laura Thompson, RN, Supervisor  
Long Term Care Program

LT/lj