



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

BRAD LITTLE – Governor  
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR  
LICENSING & CERTIFICATION  
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BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
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September 19, 2019

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

Provider #: 135015

Dear Mr. Hayes:

On **September 6, 2019**, 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 an isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

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

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **October 1, 2019**. Failure to submit an acceptable PoC by **October 1, 2019**, may result in the imposition of penalties by **October 21, 2019**.

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 **October 11, 2019 (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 **December 6, 2019**. A change in the seriousness of the deficiencies on **October 21, 2019**, 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 **December 6, 2019** includes the following:

Denial of payment for new admissions effective **December 6, 2019**. [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 **March 6, 2020**, 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 Belinda Day, RN or Laura Thompson, RN, Supervisors Long Term Care, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **December 6, 2019** 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 **October 1, 2019**.. If your request for informal dispute resolution is received after **October 1, 2019**., 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 Belinda Day, RN, or Laura Thompson, RN, Supervisors, Long Term Care Program at (208)334-6626, option #2.

Sincerely,



Laura Thompson, RN, Supervisor  
Long Term Care Program

lt/lj

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

PRINTED: 10/04/2019  
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>09/06/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS  The following deficiencies were cited during the federal recertification survey conducted from September 3, 2019 through September 6, 2019.  The surveyors conducting the survey were: Cecilia Stockdill, RN, Team Coordinator Roxie Lacey, RN  Survey Abbreviations:  DNS = Director of Nursing Services I&A = Incident and Accident LPN = Licensed Practical Nurse MAR = Medication Administration Record MDS = Minimum Data Set mg = milligrams ml = milliliters MSW = Medical Social Worker RN = Registered Nurse	F 000			
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)  §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in	F 623		10/11/19	

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

TITLE

(X6) DATE

Electronically Signed

09/30/2019

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 623	<p>Continued From page 1 paragraph (c)(5) of this section.</p> <p>§483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days.</p> <p>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal</p>	F 623			

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F 623	<p>Continued From page 2 hearing request;</p> <p>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;</p> <p>(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and</p> <p>(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.</p> <p>§483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.</p> <p>§483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).</p>	F 623			

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F 623	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the facility failed to ensure residents and/or their representative received written notification regarding transfer to the hospital, and the state ombudsman was notified of the transfer. This was true for 2 of 3 residents (#31 and #33) reviewed for transfer/discharge. This failure created the potential for harm if residents were unable to exercise their rights related to transfers due to lack of notification. Findings include:</p> <p>The facility's policy for Discharge and Transfer, revised 2/1/19, documented the following:</p> <ul style="list-style-type: none"> <li>* The facility must immediately inform the resident/representative when there is a decision to transfer or discharge the resident.</li> <li>* The resident and their representative must be notified in writing and in a language and manner they understand.</li> <li>* For unplanned, acute transfers when it was expected for the resident to return to the facility, the resident and/or their representative were "notified verbally followed by written notification using the Notice of Hospital Transfer or state specific form."</li> <li>* A copy of the notices for emergency transfer must be sent to the ombudsman, and may be sent when practicable, such as a list sent on a monthly basis or per the state's requirements.</li> </ul> <p>The policy was not followed.</p> <p>1. Resident #31 was readmitted to the facility on 8/2/19, with multiple diagnoses including wedge</p>	F 623	<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 the form exist, nor does the center admit to any statements, findings, facts, or conclusions that form the basis for the deficiencies. The center reserves the right to challenge in legal and or regulatory or administrative proceedings the deviancies, statements, facts, and conclusions that form the basis for the deficiencies.</p> <p>Affected: On or before 10/11/2019, the Notice of Discharge for residents #31 and #33 will be completed by the Licensed Social Worker or designee and presented to each resident. On or before 10/11/2019, the online Ombudsman Notice of Discharge for residents #31 and #33 will be entered by the Licensed Social Worker or designee. Copies will be printed, sent to the Ombudsman and presented to each resident. On or before 10/11/2019, the online Ombudsman Notice of Discharge for residents #31 and #33 will be entered by the Licensed Social Worker or designee. Copies will be printed, sent to the Ombudsman and presented to each resident.</p> <p>Potential:</p>		

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F 623	<p>Continued From page 4</p> <p>compression fracture of the first lumbar vertebrae (part of the spine in the lower back), and a fall from bed.</p> <p>Resident #31's discharge MDS assessment, dated 8/1/19, documented he had an unplanned discharge to the hospital, and he had problems with short term memory.</p> <p>A Change in Condition Evaluation, dated 8/1/19 at 9:02 PM, documented Resident #31 was found on the floor in his room, and he stated he rolled over in bed and fell to the floor. Resident #31 complained of back pain rated as 8 or 9 (on a scale from zero to 10), and an order was received to send him to the emergency room for evaluation. A voice message was left for both of his daughters.</p> <p>Resident #31's record did not contain documentation that written notification was provided to him and/or his representative, or the state ombudsman was notified when he was transferred to the hospital on 8/1/19.</p> <p>On 9/5/19 at 12:47 PM, the Administrator said the facility just recently started sending notices to the local ombudsman regarding transfers because they did not know whom to contact. The Administrator said there would probably not be much documentation that notification was provided to the ombudsman regarding resident transfers.</p> <p>On 9/6/19 at 8:39, the MSW said the facility had not been notifying the local ombudsman or providing written notification to the resident and/or their representative when they were</p>	F 623	<p>On or before 10/11/2019, the Licensed Social Worker or designee will complete an audit of the transfers and discharges from 09/06/2019 to identify residents who may not have received the Notice of Discharge.</p> <p>On or before 10/11/2019, the Licensed Social Worker or designee will send the Notice of Discharge to the residents identified as not having received the notice.</p> <p>On or before 10/11/2019, the online Ombudsman Notice of Discharge for residents will be entered by the Licensed Social Worker or designee. Copies will be printed, sent to the Ombudsman, and presented to each resident who had not received one.</p> <p>Systemic: On or before 10/11/2019, residents in the process of discharge or transfer will be reviewed in Daily Stand-Up IDT meeting by the Licensed Social Worker or designee for the issuance of the Notice of Discharge and the Ombudsman Notice of Discharge. Copies of each notice will be maintained by the Licensed Social Worker or Designee.</p> <p>On or before 10/11/2019, the Center Executive Director will educate the Licensed Social Worker and designee with respect to the requirements for Notification of Discharge.</p> <p>Monitor/QAPI On or before 10/11/2019, results of the Daily Stand-Up IDT Notice of Discharge</p>		

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F 623	Continued From page 5 transferred out of the facility.  On 9/6/19 at 9:58 AM, RN #2 said she assisted in completing the transfer form when a resident was transferred to the hospital, and she thought it was the facility's policy to provide the resident and/or their representative with written information regarding the transfer at the time of the transfer.  2. Resident #33 was admitted to the facility on 5/7/19, with diagnoses which included kidney disease requiring dialysis.  A hospital History and Physical, dated 6/6/19, documented Resident #33 was transported to the emergency room on 6/5/19 after a fall from a transport van resulting in a superficial head laceration.  Resident #33's record did not contain documentation that he, his representative and the state ombudsman were provided written notice of transfer to the hospital.  On 9/6/19 at 8:15 AM, the MSW stated the facility had not been providing written notifications of transfers to the residents, their representatives or the ombudsman.	F 623	audits will be reported by the Licensed Social Worker or designee in the monthly QAPI meeting, monthly for 3 months or until substantial compliance is achieved. The Center Executive Director is responsible for monitoring compliance.		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2)  §483.15(d) Notice of bed-hold policy and return-  §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that	F 625		10/11/19	

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F 625	<p>Continued From page 6</p> <p>specifies-</p> <p>(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;</p> <p>(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;</p> <p>(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and</p> <p>(iv) The information specified in paragraph (e)(1) of this section.</p> <p>§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:</p> <p>Based on policy review, record review, and staff interview, it was determined the facility failed to notify the resident and their representative of the bed hold policy upon transfer/discharge. This was true for 2 of 3 residents (#31 and #33) reviewed for transfer/discharge. This failure created the potential for harm if residents were not informed of their right to return to their former room at the facility within a specified time.</p> <p>Findings include:</p> <p>The facility's policy for Bed Hold Notice, effective January 2019, documented: "Prior to a resident's transfer out of the center to a hospital or for therapeutic leave, the staff member conducting</p>	F 625	<p>Affected:</p> <p>On or before 10/11/2019, the Licensed Social Worker or designee will present the Bed Hold Policy and Authorization to residents #31 and #33.</p> <p>Potential:</p> <p>On or before 10/11/2019, the licensed Social Worker or designee will review the temporary transfers and discharges from 09/06/2019 to identify any other residents who may not have received the Bed Hold Policy and Authorization.</p> <p>On or before 10/11/2019, the Licensed Social Worker or designee will present</p>		

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F 625	<p>Continued From page 7</p> <p>the transfer out will provide both the resident and representative, if applicable, with the [Bed] Hold Policy Notice &amp; Authorization form. Notice must be given regardless of payer ..."</p> <p>This policy was not followed.</p> <p>1. Resident #31 was readmitted to the facility on 8/2/19, with multiple diagnoses including wedge compression fracture of the first lumbar vertebrae (part of the spine in the lower back) and a fall from bed.</p> <p>Resident #31's discharge MDS assessment, dated 8/1/19, documented he had an unplanned discharge to the hospital, and he had problems with short term memory.</p> <p>A Change in Condition Evaluation, dated 8/1/19 at 9:02 PM, documented Resident #31 was found on the floor in his room, and he stated he rolled over in bed and fell to the floor. Resident #31 complained of back pain rated as 8 or 9 (on a scale from zero to 10), and an order was received to send him to the emergency room for evaluation. A voice message was left for both of his daughters.</p> <p>Resident #31's record did not contain documentation that a bed hold notice was provided to him or his representative when he was transferred to the hospital on 8/1/19.</p> <p>On 9/5/19 at 9:25 AM, the DNS said the MSW was the one who handled bed hold notices and transfers.</p> <p>On 9/5/19 at 10:29 AM, the MSW said Resident</p>	F 625	<p>the Bed Hold Policy and Authorization to residents identified as not having received the policy</p> <p>Systemic: On or before 10/11/2019, residents in the process of transfer or leave of absence will be reviewed in Daily Stand-Up IDT meeting by the Licensed Social Worker or designee for the issuance of the Bed Hold Policy and Authorization. Copies of each notice will be maintained by the Licensed Social Worker or Designee. On or before 9/30/19, the Center Executive Director or designee will educate the Licensed Social Worker and designee on the bed hold policy.</p> <p>Monitor/QAPI: On or before 10/11/2019, The Licensed Social Worker or designee will review residents who are transferred or go on a leave of absence for the presence of completed bed hold policies. On or before 10/11/2019, All findings will be presented in the monthly QAPI meeting for 3 months or until substantial compliance is achieved. The Center Executive Director is responsible for monitoring compliance.</p>		

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F 625	Continued From page 8 #31 was not gone from the facility for 24 hours, so he was not offered a bed hold notice. The MSW said if Resident #31 was gone from the facility for 24 hours, the facility would have called his daughter about the bed hold notice.  On 9/6/19 at 9:58 AM, the MSW said a bed hold notice was not provided to Resident #31 or his representative for his transfer on 8/1/19.  2. Resident #33 was admitted to the facility on 5/7/19, with diagnoses which included kidney disease requiring dialysis.  A hospital History and Physical, dated 6/6/19, documented Resident #33 was transported to the emergency department on 6/5/19 after a fall from a transport van resulting in a superficial head laceration.  Resident #33's record did not contain documentation that a bed hold notice was provided to him or his representative when he was transferred to the hospital on 6/5/19.  On 9/6/19 at 8:15 AM, the MSW stated the facility was not providing written notification of bed holds to the resident or their representative when a resident was transferred.	F 625			
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii)  §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.	F 636		10/11/19	

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F 636	<p>Continued From page 9</p> <p>§483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:</p> <ul style="list-style-type: none"> <li>(i) Identification and demographic information</li> <li>(ii) Customary routine.</li> <li>(iii) Cognitive patterns.</li> <li>(iv) Communication.</li> <li>(v) Vision.</li> <li>(vi) Mood and behavior patterns.</li> <li>(vii) Psychological well-being.</li> <li>(viii) Physical functioning and structural problems.</li> <li>(ix) Continence.</li> <li>(x) Disease diagnosis and health conditions.</li> <li>(xi) Dental and nutritional status.</li> <li>(xii) Skin Conditions.</li> <li>(xiii) Activity pursuit.</li> <li>(xiv) Medications.</li> <li>(xv) Special treatments and procedures.</li> <li>(xvi) Discharge planning.</li> <li>(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).</li> <li>(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.</li> </ul> <p>§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive</p>	F 636			

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F 636	<p>Continued From page 10</p> <p>assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.</p> <p>(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)</p> <p>(iii) Not less than once every 12 months. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, policy review, and resident and staff interview, it was determined the facility failed to ensure residents' MDS assessments accurately reflected their status at the time of the assessment. This was true for 1 of 12 residents (Resident #30) whose MDS assessments were reviewed. This failure created the potential for harm if care decisions were based upon inaccurate information. Findings include:</p> <p>The facility's policy for Nursing Assessment, revised 2/1/19, documented "The assessment must accurately reflect the patient's status at the time of assessment."</p> <p>Resident #30 was readmitted to the facility on 12/4/17, with multiple diagnoses including flaccid hemiplegia (weakness or paralysis on one side) affecting the left side, and abnormalities of gait and mobility.</p> <p>A Progress Note, dated 4/27/19 at 3:29 PM,</p>	F 636	<p>Affected: On 09/05/19, the MDS for resident #30 (dated 5/4/19) was modified by the MDS Nurse to reflect the fall that occurred on 4/27/19</p> <p>Potential: On or before 10/11/2019, the MDS nurse or designee will audit falls that occurred in the last 90 days to identify any resident's MDS which way have errors. On or before 10/11/2019, Issues found during the MDS audit will be corrected by the MDS Nurse.</p> <p>Systemic: On or before 10/11/2019, the Center Nurse Executive will educate the MDS nurse on the fall policy and capturing falls on the MDS per policy. On or before 10/11/2019, the Center Nurse Executive will report recent falls in the Daily Stand-Up IDT Meeting. The</p>		

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F 636	Continued From page 11 documented Resident #30 had a change in condition related to a fall on 4/27/19 in the afternoon.  An I&A report, dated 4/27/19, documented Resident #30 was found on the floor between her recliner and wheelchair, and she fell when she attempted to transfer herself to the recliner.  Resident #30's quarterly MDS assessment, dated 5/14/19, documented she had no falls since admission or the prior assessment. The assessment did not document Resident #30's fall, which occurred 17 days prior to the assessment, on 4/27/19.  On 9/3/19 at 1:59 PM, Resident #30 said she fell "a couple months ago" and hurt her shoulder.  On 9/5/19 at 1:56 PM, the MDS Nurse stated she missed Resident #30's fall on the quarterly MDS assessment, dated 5/14/19, and she was going to modify the MDS assessment.	F 636	MDS nurse will follow-up on identified residents and report MDS status the following day.  Monitor/QAPI: On or before 10/11/2019, the Center Nurse Executive or designee will audit 3 completed MDS's for 4 weeks and then 3 for 2 months. On or before 10/11/2019, MDS audit findings will be reviewed in the monthly QAPI meeting for 3 months or until substantial compliance is achieved. The Center Executive Director is responsible for monitoring compliance.		
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.	F 657		10/11/19	

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F 657	<p>Continued From page 12</p> <p>(D) A member of food and nutrition services staff.</p> <p>(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.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure residents' care plans were updated to maintain consistency and accuracy. This was true for 1 of 12 residents (Resident #21) whose care plans were reviewed. This failure created the potential for harm if cares and/or services were not provided due to missing information on the care plan. Findings include:</p> <p>The facility's policy for Person-Centered Care Plan, revised on 7/1/19, documented the following:</p> <ul style="list-style-type: none"> <li>* A comprehensive person-centered care plan must be developed for each resident and must include services that must be furnished.</li> <li>* "The care plan must be customized to each individual patient's preferences and needs."</li> <li>* The care plan was communicated to the appropriate staff, resident, health care decision</li> </ul>	F 657	<p>Affected: On 09/25/2019, the care plan for Resident #21 was revised by the Center Nurse Executive to include pneumonia and nebulizer treatments being given.</p> <p>Potential: On or before 10/11/2019, the Center Nurse Executive or designee will audit current residents with nebulizer treatments for completion and accuracy. Any discovered issues will be corrected.</p> <p>Systemic: On or before 10/11/2019, during the daily IDT CAR meeting, the Center Nurse Executive or designee will audit care plans for residents with doctor's orders for inclusion of the ordered interventions and follow-up as needed to insure care plans are completed as required by facility</p>		

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F 657	<p>Continued From page 13 maker, and family. * The care plan was reviewed and revised by the interdisciplinary team after each assessment and as needed to reflect the resident's response to care and changing needs and goals.</p> <p>This policy was not followed.</p> <p>Resident #21 was readmitted to the facility on 7/11/19, with multiple diagnoses including pneumonia, acute and chronic respiratory failure, and pulmonary embolism (a blood clot in the lung.)</p> <p>Resident #21's physician orders, dated 9/3/19, documented an order for ipratropium-Albuterol Solution (medication to dilate the breathing passages that is administered by a nebulizer- a machine that delivers the medication as an inhaled mist ) 0.5-2.5 mg /3 ml inhale every 6 hours as needed for a history of pneumonia. The ipratropium-Albuterol Solution was ordered on an as needed basis on 8/26/19.</p> <p>Resident #21's MAR, dated August 2019, documented the ipratropium-Albuterol Solution was administered every four hours each day from 8/1/19 through 8/26/19, and it started on 7/22/19. The routinely scheduled ipratropium-Albuterol Solution was discontinued on 8/26/19.</p> <p>Resident #21's MAR, dated September 2019, documented the ipratropium-Albuterol Solution was available to be used every 6 hours as needed.</p> <p>Resident #21's care plan did not document he received ipratropium-Albuterol nebulizer</p>	F 657	<p>policy. On or Be3fore 10/11/2019, the Center Nurse Executive or designee will educate Licensed Nurses on MD orders and Care Plans.</p> <p>Monitor/QAPI: On or Before 10/11/2019, the Center Nurse Executive or designee will audit 3 residents care plans per week for 4 weeks, then monthly for 2 months, for inclusion of ordered treatments. Results of the audits and any necessary corrective actions will be reported in the monthly QAPI for 3 months or until substantial compliance is achieved. The Center Nurse Executive is responsible for monitoring compliance.</p>		

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F 657	Continued From page 14 treatments.  On 9/3/19 at 2:10 PM and on 9/5/19 at 11:32 AM, a nebulizer machine, tubing, and administration set were present on the bedside table in Resident #21's room.  On 9/5/19 at 11:33 AM, LPN #1 said Resident #21 received nebulizer treatments as needed.  On 9/5/19 at 12:56 PM, the DNS said she did not see the specifics about the nebulizer treatments on Resident #21's care plan.  On 9/6/19 at 10:03 AM, RN #2 said the nurse who received a physician's order added the information to the care plan, or if she noticed it she added it to the care plan. RN #2 said Resident #21's nebulizer treatments should be on the care plan.	F 657			
F 684 SS=D	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 record review, policy review, review of I&A Reports, and staff interview, it was determined the facility failed to ensure neurological assessments were completed after	F 684	Affected: On 9/30/19, the Center Nurse Executive or designee completed neurological assessments for residents #30 and #31	10/11/19	

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F 684	<p>Continued From page 15</p> <p>unwitnessed falls per the facility's policy. This was true for 2 of 4 residents (#30 and #31) reviewed for falls. This failure created the potential for harm should residents experience undetected changes in neurological status. Findings include:</p> <p>The facility's policy for Falls Management, revised 3/15/16, directed staff to perform neurological assessments for all unwitnessed falls and when a fall was witnessed with head injury.</p> <p>The facility's policy for Neurological Assessment, revised 10/1/12, directed staff to perform neurological assessments when a resident sustained an injury to their head and/or when a fall was unwitnessed.</p> <p>These policies were not followed.</p> <p>1. Resident #31 was readmitted to the facility on 8/2/19, with multiple diagnoses including wedge compression fracture of the first lumbar vertebrae (part of the spine in the lower back) and a fall from bed.</p> <p>Resident #31's discharge MDS assessment, dated 8/1/19, documented the following:</p> <ul style="list-style-type: none"> <li>* He had problems with short term memory.</li> <li>* He had one fall since admission or the prior assessment.</li> </ul> <p>A Change in Condition Evaluation, dated 8/1/19 at 9:02 PM, documented Resident #31 was found on the floor in his room, and he stated he rolled over in bed and fell to the floor. Resident #31</p>	F 684	<p>with no issues found.</p> <p>Potential: On or before 10/11/2019, the Center Nurse Executive or designee will audit medical records of residents experiencing falls in the last 90 days for inclusion of Neurological Assessments. On or before 10/11/2019, a Neurological Assessment will be completed by the Center Nurse Executive or designee for any which may be found to be incomplete.</p> <p>Systemic: On or before 10/11/2019, the Center Nurse Executive or designee will educate nursing staff on the neurological assessment policy with return demonstration. On or before 10/11/2019, residents experiencing falls or other such accidents will be reviewed in the daily IDT CAR meeting, with assessments, evaluations, and interventions directed as necessary with follow-up until resolution.</p> <p>Monitor/QAPI: The Center Nurse Executive or designee will audit residents with falls each week for 4 weeks and monthly for 2 months to ensure the neurological assessment is completed per policy. Findings will be presented in the monthly QAPI meeting for 3 months or until substantial compliance is achieved. The Center Nurse Executive is responsible for monitoring compliance</p>		

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F 684	<p>Continued From page 16 stated he hit his head and back.</p> <p>Resident #31's Neurological Assessment Flow Sheet was lacking the following documentation:</p> <ul style="list-style-type: none"> <li>* On 8/2/19 at 8:45 PM and 9:45 PM, and on 8/3/19 at 1:45 AM and 5:45 AM, the areas for documenting level of consciousness, Pupil Response, Motor Functions, and Pain Response were blank.</li> <li>* On 8/2/19 at 9:45 PM, the areas for documenting vital signs were blank.</li> <li>* On 8/3/19 at 1:45 PM, the areas for documenting vital signs were blank.</li> </ul> <p>On 9/5/19 at 9:06 AM, the DNS said neurological assessments should be done when a resident fell and struck their head, and if the fall was unobserved. The DNS said there were incomplete areas on Resident #31's Neurological Assessment Sheet related to his fall on 8/1/19.</p> <p>2. Resident #30 was readmitted to the facility on 12/4/17, with multiple diagnoses including flaccid hemiplegia (weakness or paralysis on one side) affecting the left side and abnormalities of gait and mobility.</p> <p>A Progress Note, dated 4/27/19 at 3:29 PM, documented Resident #30 had a change in condition related to a fall.</p> <p>An I&amp;A report, dated 4/27/19, documented Resident #30 had an unwitnessed fall when she attempted to transfer herself to the recliner. Resident #30 was found on the floor between her recliner and wheelchair.</p>	F 684			

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F 684	Continued From page 17 Resident #30's Neurological Assessment Flow Sheet was lacking the following documentation :  * On 4/27/19 at 5:30 PM, 6:00 PM, and 6:30 PM, the areas for documenting level of consciousness, pupil response, and motor function, were blank. "Dining Room" was documented in the areas for documenting pain response and vital signs.  On 9/5/19 at 1:49 PM, LPN #1 said neurological assessments should be done if a fall was unwitnessed and if the resident hit their head. LPN #1 said all the required information should be completed on the Neurological Assessment Flow Sheet.  On 9/5/19 at 2:45 PM, the DNS said there were areas missing neurological assessments on Resident #30's Neurological Assessment Flow Sheet. The DNS said she expected the neurological assessments to be done, even when Resident #30 was in the dining room, unless Resident #30 did not want them done.	F 684			
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)  §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.  §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must	F 690		10/11/19	

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NAME OF PROVIDER OR SUPPLIER  <b>PAYETTE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1019 THIRD AVENUE SOUTH PAYETTE, ID 83661</b>		
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F 690	<p>Continued From page 18</p> <p>ensure that-</p> <p>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;</p> <p>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and</p> <p>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.</p> <p>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, staff interview, and resident family interview, it was determined the facility failed to ensure residents received bowel care in accordance with standard nursing practice and physician orders. This was true for 1 of 1 resident (Resident #27) reviewed for constipation. This failure created the potential for harm should residents experience negative effects from constipation or fecal impaction (a mass of stool that is so hard it cannot be passed). Findings include:</p> <p>Resident #27 was admitted to the facility on</p>	F 690	<p>Affected: On or before 09/27/2019, the Center Nurse Executive or designee will assess the resident for any adverse reactions any issues found will be immediately addressed.</p> <p>Potential: On or before 10/11/2019, the Center Nurse Executive or designee will audit current records for the presence of documentation of bowel movements and follow-up treatment that may be indicated.</p>		

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F 690	<p>Continued From page 19 4/23/19, with diagnoses which included Parkinson's disease (a progressive nervous system disorder that affects movement) and weakness.</p> <p>Resident #27's physician orders included the following bowel protocol standing orders, dated 4/23/19:</p> <ul style="list-style-type: none"> <li>* Milk of Magnesia Suspension 400 MG/5ML (MOM)-Give 30 ml by mouth as needed for constipation. Give at bedtime if no BM (bowel movement) in 3 days.</li> <li>* Dulcolax Suppository 10 MG (Bisacodyl) Insert 1 suppository rectally as needed for constipation if no result from MOM or Miralax (laxative) by the next shift.</li> <li>* Fleet Enema-Insert 1 dose rectally as needed for constipation if no result from Dulcolax within 2 hours. If no results from Fleet enema, call MD (Medical Doctor)/advanced practice provider (APP) for further orders.</li> </ul> <p>Resident #27's ADL (Activities of Daily Living) sheets documented he did not have a bowel movement from 8/22/19 through 8/29/19 (8 days).</p> <p>Resident #27's MAR documented a Dulcolax suppository was administered on 8/30/19, and the suppository was effective resulting in a bowel movement on 8/30/19.</p> <p>On 9/3/19 at 9:45 AM, Resident #27's family member stated she was told by a CNA (Certified Nursing Assistant) that Resident #27 was given a</p>	F 690	<p>On or before 10/11/2019, the Center Nurse Executive or designee will direct any follow-up treatment or intervention which may be necessary.</p> <p>Systemic: On or before 10/11/2019, the Center Nurse Executive or designee will audit bowel care sheets and report results in the weekly IDT CAR meeting. On or before 10/11/2019, the Center Nurse Executive or designee will direct and follow-up on additional documentation or interventions which may be necessary On or before 10/11/2019, the Center Nurse Executive or designee will educate Licensed Nurses regarding bowel protocol.</p> <p>Monitor/QAPI: On or before 10/11/2019, the Center Nurse Executive or designee will audit 3 residents each week for 4 weeks and monthly for 2 months for bowel documentation and treatment per bowel protocol. On or before 10/11/2019, findings will be brought through the QAPI meeting monthly for 3 months or until substantial compliance is achieved. The Center Nurse Executive is responsible for monitoring compliance</p>		

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F 690	Continued From page 20 suppository because he did not have a bowel movement in nine days.	F 690			
F 698 SS=D	On 9/5/19 at 9:00 AM, the DNS stated she was aware that staff did not intervene for Resident #27 after three days with no bowel movement. The DNS stated that staff were to follow the facility's bowel protocol standing orders.  Dialysis CFR(s): 483.25(l)  §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, record review, and resident and staff interviews, it was determined the facility failed to ensure that post-dialysis assessments were consistently completed. This was true for for 2 of 2 residents (Resident #30 and #33) reviewed for dialysis, and created the potential for harm if complications were undetected and untreated. Findings include:  The facility's policy for Dialysis: Hemodialysis (HD)- Communication and Documentation, revised on 10/1/18, documented, "Upon return of the patient to the center, a licensed nurse will: Complete the post-hemodialysis treatment section on the Hemodialysis Communication Record or state required form ..."  1. Resident #30 was readmitted to the facility on	F 698	Affected: On or before 09/27/19, the Center Nurse Executive or designee will assess resident #30 and 33 to verify if vital signs and AV fistula/graft are within normal limits, and identify any adverse reactions which may be present. Any issues found will be immediately addressed.  Potential: On or before 10/11/2019, the Center Nurse Executive or designee will audit current dialysis resident's communication sheets for completion upon return from the dialysis provider.  Systemic: On or before 10/11/2019, nursing staff will be educated on the dialysis	10/11/19	

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F 698	<p>Continued From page 21 12/4/17, with multiple diagnoses including Type 2 diabetes mellitus, dependence on dialysis, and end stage renal (kidney) disease.</p> <p>Resident #30's quarterly MDS assessment, dated 8/13/19, documented she was severely cognitively impaired and she received dialysis.</p> <p>Resident #30's physician orders, dated 9/3/19, documented the following:</p> <ul style="list-style-type: none"> <li>* Treatment at a dialysis center every Monday, Wednesday, and Friday, ordered on 1/7/19.</li> <li>* Monitor AV (arteriovenous) fistula/graft (a connection between an artery and vein, surgically created for dialysis) for signs and symptoms of infection, swelling, and bleeding upon return from dialysis. Notify the primary physician and dialysis center if signs and symptoms of infection. If bleeding from the AV site, apply pressure for 15 minutes and notify the physician, ordered on 12/4/17.</li> <li>* Monitor right fistula site for redness, increased pain, increased pus-like discharge, bleeding, or loss of sensation below the site, every day and night shift, ordered on 2/27/19.</li> </ul> <p>Resident #30's Hemodialysis Communication Records contained a section to be completed by the facility's licensed nurse after dialysis treatments. The required documentation included the assessment of the access site, vital signs, condition of the AV fistula/graft, post-hemodialysis complications, new orders from the dialysis center, and the receiving licensed nurse's signature. All of the required areas were blank in the section for post dialysis treatment on 6/24/19, 8/1/19, 8/2/19, 8/9/19,</p>	F 698	<p>communication form and protocol by the Center Nurse Executive or designee. On or before 10/11/2019, a Fistula monitor line will be added by the Center Nurse Executive or designee on the MAR/TAR for each dialysis resident for the purpose of monitoring of the Fistula site. On or before 10/11/2019, Dialysis books will be brought to the weekly CAR meeting by the Center Nurse Executive or designees to monitor proper completion of the communication form.</p> <p>Monitor/QAPI: On or before 10/11/2019, The Center Nurse Executive or designee will audit 3 residents on dialysis weekly for 4 weeks and monthly for 2 months to ensure that communication forms are being sent with the resident to dialysis and filled out completely upon return. All findings will be brought through QAPI monthly for 3 months or until substantial compliance is met. The Center Nurse Executive will be responsible for monitoring compliance</p>		

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

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OMB NO. 0938-0391

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F 698	<p>Continued From page 22 8/16/19, 8/21/19, 8/23/19, and 8/28/19 (8 of 16 dialysis days).</p> <p>On 9/5/19 at 2:20 PM, LPN #1 said Resident #30 went to dialysis on that day and had returned to her room. LPN #1 said when Resident #30 returned from dialysis, he checked her AV fistula site and vital signs. LPN #1 said he had not completed the Hemodialysis Communication Record on that day. When reviewing the previous Hemodialysis Communication Records, LPN #1 said staff were not doing a very good job at documenting on the post dialysis section.</p> <p>On 9/5/19 at 2:25 PM, Resident #30 was sitting in the recliner in her room, and she said she had been to dialysis on that day. A dressing was in place to her right upper arm with some visible red/brown drainage on the dressing, and bruising was observed to her inner right upper arm. Resident #30 said when she returned from dialysis the nurses did nothing.</p> <p>On 9/5/19 at 2:48 PM, the DNS said the nurse should complete the post dialysis section of the Hemodialysis Communication Record after Resident #30's dialysis treatments.</p> <p>2. Resident #33 was admitted to the facility on 6/18/19, with diagnoses which included kidney disease requiring dialysis.</p> <p>Resident #33's Physician's Order, dated 6/18/19, documented: "Monitor AV fistula/graft site for S/S (signs and symptoms) of infection, edema (swelling), and bleeding upon return from dialysis. Notify primary care physician and dialysis unit if there are signs and symptoms of</p>	F 698			

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F 698	Continued From page 23 infection. If AV fistula/graft site is bleeding apply pressure for 15 minutes and notify MD/Physician extender if bleeding does not stop. [Assess] every day shift and every night shift."  Upon review of Resident #33's record, the Hemodialysis Communication Records were not completed upon return to the facility on 8/5/19, 8/9/19, 8/19/19, 8/30/19, and 9/2/19 (5 of 16 opportunities).  On 9/5/19 at 3:00 PM, RN #1 stated Resident #33 and his AV fistula should be assessed, and the Hemodialysis Communication Record should be completed.	F 698		

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C 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the State licensure survey of your facility.</p> <p>The surveyors conducting the survey were: Cecilia Stockdill, RN, Team Coordinator</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 all rooms in 1 of 3 halls (100 Hall) and the closets in rooms 201 and 203 on the 200 Hall. Findings include:</p> <p>On 9/6/19 at 11:10 AM, the Administrator said a waiver would be requested again to allow for less than the required closet space. All closets in the 100 hall measured 36 inches wide and 24 inches deep. The closets had dividers separating them, which created individual closet space of 18 inches wide by 24 inches deep. The same was true of rooms 201 and 203.</p>	C 490	<p>Payette Center requests an extension of the current waiver to allow for less than the required closet space.</p>	10/11/19

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

Electronically Signed

TITLE

(X6) DATE  
09/30/19