STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135015	A. Building B. Wing	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Payette Healthcare of Cascadia	1019 Third Avenue South Payette, ID 83661

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 51121 Based on policy review, observation, record review, and interviews, it was determined the facility failed to ensure a resident was initially assessed to determine if they were safe to self-administer medications for 1 of 2 residents (Resident #36). This failure created the potential for adverse effects if Resident #36 self-administered medications inappropriately. Findings include: The facility's Self-Administration of Medications policy, dated 11/28/17, stated in part 2. The interdisciplinary team determines that it is safe for the resident to self-administer drugs before the resident is allowed to do so, and the decision is periodically reviewed according to the resident's status. 2a. Qualify nursing staff administers drugs until the determination is made. Resident #36 was admitted to the facility 12/29/23, with multiple diagnoses including incomplete quadriplegia (characterized by weakness or paralysis of all four limbs), diabetes with diabetic polyneuropathy (affects multiple peripheral sensory and motor nerves that branch out form the spinal cord into the arms, hands, legs, and feet), and gastro-esophageal reflux. On 8/4/24 at 2:12 PM, Resident #36 stated he was given calcium carbonate oral chewable tablets at bedside to use when he thought he needed them. He stated his nurse had given him 6 tablets and he already had taken two and still had 4 additional tablets in his dresser drawer. No self-administration medication assessment was documented in his medical records. An email from the DON on 8/7/24 at 2:52 PM, documented the self-administration medication assessment was not completed for Resident #36. During a follow-up interview with the DON on 8/7/24 at 4 PM, she confirmed the self-administration medication assessment had not been completed for Resident #36.

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49552 Based on observation, policy review, and staff interview, it was determined the facility failed to ensure residents were provided with a safe, clean, homelike environment. This was true for 1 of 4 residents (Resident #36) who were observed in power wheelchairs, and for all 44 residents who resided in the facility whose overall environment was observed. This deficient practice created the potential for harm if: a) residents were injured when the privacy curtains in the resident's rooms prevented the resident from moving around in their room safely and the holes in the floors caused a resident to fall, b) residents were embarrassed by dirty equipment and/or felt the lack of cleanliness in the facility was unacceptable, disrespectful, or undignified, and c) cross-contamination from spread of microorganisms. Findings include: The facility's General Environmental Condition policy, revised 9/1/18, documented a safe, functional, sanitary, and comfortable environment is provided for residents, staff, and the public. 1. Resident #36 was admitted to the facility 12/29/23, with multiple diagnoses including incomplete quadriplegia (characterized by weakness or paralysis of all four limbs), diabetes with diabetic polyneuropathy (affects multiple peripheral sensory and motor nerves that branch out form the spinal cord into the arms, hands, legs, and feet), and muscle weakness. On 8/4/24 at 2:08 PM, Resident #36 stated he had difficulty maneuvering his power wheelchair in his room due to the 2 ceiling curtains which often tangled up in the wheelchair when going between the 2 beds and going to the bathroom. At the time of this visit, Resident #36 was the only resident assigned to this room. He stated staff did not let him put the curtain material on the extra bed because that bed may be assigned to another resident at some point. 2. Resident #33 was admitted to the facility 3/24/23, with multiple diagnoses including diabetes, Crohn's disease (a chronic inflammatory bowel disease that affect the lining of the digestive tract), and depression. On 8/5/24 at 8:30 AM, Resident #33 stated the fan in his bathroom was not working. Additionally, he said he had reported this over several months, to a CNA, housekeeping staff, and the floor nurse but the fan had not been repaired. On 8/6/24 at 9:49 AM, the MS stated all staff who have access to PCC TELS (maintenance managment system) can report maintenance related issues. The PCC TELS system sends a note right to the MS for quick notice. The MS explained that staff who do not have PCC access can submit maintenance relate issues via a notebook located in the facility copier room. When reviewed, the last entry in the maintenance request notebook was 3/2023. A review of the PCC TELS system maintenance log for the last 3 months did not identify any maintenance requests for Resident #33's non-function bathroom fan. 3. The following common residential environment area were observed as unsafe and unsanitary: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. On 8/4/24 at 12:15 PM, a 5 inch long by 2 inch wide, and 1/2 deep hole in dining room floor tile with lifted edges creating a potential fall or trip hazard was observed. On 8/6/24 at 9:44 AM, the DON stated she did not remember seeing the hole in the dining room tile. On 8/6/24 at 9:46 AM, the MS stated he did not remember seeing the hole in the dining room tile but agreed it is a potential trip hazard and should have been repaired. b. On 8/7/24 at 10:00 AM, the west side shower room was observed with: - at the entrance of the shower room an area approximately 6-inch x 5-inch with missing floor tiles was observed. - in front of the cupboards on the shower room wall, the floor tile had a crack, approximately 12-inch long. - the right side of the floor was observed with a floor tile that was cracked and dipped inward, approximately 14-inch x 2-inch x 1/4-inch deep. - to the left side of the entrance into shower area, observed a screw hanging loose from the base board. On 8/7/24 at 10:05 AM, the west side shower room was observed with: - the air vent had a layer of dust on it. - the top left side of the window had large, thick, white cobweb. c. On 8/7/24 at 12:14 PM, observed west hall flooring was missing between: - room [ROOM NUMBER] and room [ROOM NUMBER], approximate size, 11-inch x 1-inch. - room [ROOM NUMBER] and 117, approximate size, 2-inch x 4-inch triangular shape. On 8/7/24 at 4:14 PM, the Maintenance Supervisor (MS), stated the floor in the west side shower room was a fall hazard and the facility had gotten a bid on the repair but, the bid was not approved to have it replaced. d. On 8/7/24 at 10:14 AM, the east side shower room was observed with: - the air vent had a layer of dust on it. - a shower chair had a large pink substance on the seat. CNA #4 attempted to clean the pink substance off the shower chair, but was unable to remove it. On 8/7/24 at 10:20 AM, CNA #4 stated she was not sure who cleans the air vents, but maintenance probably will clean the vents. She also stated she was not sure what the pink substance was on the shower chair seat. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/7/24 at 4:14 PM, the MS stated housekeeping should clean the shower rooms everyday by wiping things down and dusting the vents. On 8/8/24 at 10:16 AM, housekeeper #1 stated the shower rooms should be cleaned daily. She also stated, cleaning of the shower room consists of sanitizing the room, sweep and mop the floor, and cleaning the shower walls. 51121

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49552 Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure adequate care and treatment was provided to 1 of 1 resident (Resident #156) reviewed for feeding tube use. This created the potential for harm if complications developed from improper tube feeding practice. Finding include: The facility's Enteral Feeding: Gravity/Bolus policy, revised 3/10/21, directed staff to label and date opened containers of formula and refrigerate as soon as possible. Resident #156 was admitted to the facility on [DATE], with multiple diagnoses including stroke and dysphagia (difficulty swallowing). A physician's order, dated 8/1/24, documented Resident #156 was to receive Jevity 1.5 (a type of feeding formula that provides complete, balanced nutrition) or equivalent 240 ml via pump or syringe per PEG (Percutaneous endoscopic gastrostomy) tube every 4 hours. On 8/5/24 at 9:13 AM, an opened bottle of Ready-To-Hang Jevity 1.5 was observed in Resident #156's room on his bedside table. The bottle was labeled, opened 8/5/24 at 2330, 60ml/hour. On 8/7/24 at 12:00 PM, RN #2 was observed administering Ready-To-Hang Jevity 1.5 to Resident #156. RN #2 did not label the opened bottle of Ready-To-Hang Jevity 1.5. The opened bottle of Ready-To-Hang Jevity 1.5 was left on Resident #156's bedside table. On 8/7/24 at 12:19 PM, RN #2 stated, the Ready-To-Hang Jevity 1.5 bottle is used in a day, so it stays at the bedside until used. On 8/8/24 at 9:21 AM, the Clinical Resource Nurse stated the Ready-To-Hang Jevity 1.5 should have been refrigerated after it was opened.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 51121 Based on observation, interview, and record review, the facility failed to ensure 1 of 5 residents (Resident #14) received continuous oxygen via nasal cannula prescribed by the physician. This created the potential for Resident #14 to experience respiratory difficulties/impaired breathing. Findings include: Resident #14 was admitted to the facility 7/17/19, with multiple diagnoses including stroke, dysphagia (difficulty swallowing), and dependence on supplemental oxygen. Resident #14's oxygen was ordered at 2 liters per minute, via nasal cannula continuously. On 8/4/24 at 12:03 PM, CNA #2 removed Resident #14 from the portable liquid oxygen and stated she was going to top off the unit with liquid oxygen. Resident #14 was without her oxygen for over 4 minutes. Upon return CNA #2 reconnected Resident #14 nasal cannula to the portable liquid oxygen unit. On 8/7/24 at 12:15 PM, CNA #2 stated she should not have removed Resident #14 from her oxygen without first providing a backup oxygen source.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 49552 Based on staff interview and review of annual competency evaluations, it was determined the facility failed to ensure each CNA's performance was evaluated at least once every 12 months and annual evaluations were performed. This was true for 1 of 5 CNAs (CNA #3) whose personnel records were reviewed. This failure created the potential for incompetent CNAs providing care and increased the risk for harm for 44 of 44 residents living in the facility. Findings include: Annual performance evaluations were requested for 5 CNAs. On 8/7/24 at 2:22 PM, review of CNA #3's employee file documented her hire date as 5/1/20. CNA #3's employee file did not have an annual evaluation for 2022 or 2023. On 8/8/24 at 10:22 AM, the DON stated the CNA's evaluations should be done annually. She also stated CNA #3's evaluation had not been done; she had missed some of the employees annual evaluations.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 51121 Based on observation, interviews, and facility policy review, it was determined the facility failed to ensure wound care products and resident prescribed wound care cream were secured in a locked treatment care. This was observed in 1 of 2 treatment carts. This failure created the potential for residents to obtain prescribed wound care cream used for other residents and presented the risk for cross-contamination of wound care products stored in the cart. Findings include: The facility's Medication Management policy, revised 10/15/22, stated in part Medications and biologicals are stored appropriately according to manufacturer's guidelines and to prevent unauthorized access. Unlocked medication/treatment carts are under nurse control at all times. On 8/4/24 at 11:03 AM, west hall wound care treatment cart was observed to be unlocked when the nurse was not present. On 8/4/24 at 11:13 AM, LPN #1 stated she thought the cart needed to be closed and locked when she was not near it. On 8/8/24 at 10:10 AM, the DON stated treatment carts should be locked when a nurse is not present.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51121 Based on observation and staff interviews, the facility failed to ensure adherence to infection control and prevention practices to provide a safe and sanitary environment, when staff did not follow hand hygiene protocols, properly clean Hoyer lift equipment, and follow proper protocol during tube feeding. These failures had the potential to impact 4 of 4 residents (Residents #8, #15, #16, and #21) for hand hygiene, Hoyer lift use for transfers, and 1 of 1 resident (Resident #156) during G-tube feeding, placing them all at risk for cross-contamination and infection. Findings include: The CDC Long-term Care Facilities Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions (EBP) in Nursing Homes, dated 6/28/24, documented indwelling medical devices and wounds are risk factors for colonization with a MDRO. Once colonized, these residents can serve as sources of transmission within the facility. The expansion of EBP for all residents with wounds or indwelling medical devices is intended to protect these high-risk individuals both from acquisition and from serving as a source of transmission if they have already become colonized. Enhanced Barrier Precautions are recommended for residents with indwelling medical devices or wounds, who do not otherwise meet the criteria for Contact Precautions, even if they have no history of MDRO colonization or infection and regardless of whether others in the facility are known to have MDRO colonization. This is because devices and wounds are risk factors that place these residents at higher risk for carrying or acquiring a MDRO and many residents colonized with a MDRO are asymptomatic or not presently known to be colonized. 1. The following were observed for hand hygiene: On 8/4/24 at 11:51 AM, the surveyor observed in the dining room CNA #4 picked up dirty washcloths without gloves. Then without performing hand hygiene, CNA #4 washed Resident #2's hands and face. On 8/8/24 at 9:26 AM, during a interview, CNA #4 stated she should not have placed the dirty washcloths on the residents dining table and she should have washed her hands prior to helping Resident #2 wash her hands and face before the lunch meal. On 8/4/24 at 12:29 PM, the surveyor observed food trays being delivered and set up on over-bed tables in resident rooms. CNA #1 and CNA #2 had not offered to help residents wash hands before eating. One 8/4/24 at 12:32 PM, CNA #1 stated she thought the CNAs working the floor provide oral care and offered residents, eating in their rooms, hand hygiene before their meal arrives. On 8/4/24 at 12:38 PM, RN #1 stated the residents that choose to eat in their rooms are able to wash their own hands. On 8/6/24 at 10:27 AM, the DON stated staff are to encourage residents to wash their hands prior to meals in their rooms. 2. The following was observed for clean equipment: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/4/24 at 2:35 PM, observed CNA #7 replace Hoyer lift back in storage room without cleaning after resident transfer. CNA #7 stated she had just completed a resident transfer with the Hoyer lift. On 8/6/24 at 9:43 AM, the DON stated if the Hoyer lift was not cleaned after use, that was wrong. 49552 3. The following were observed for G-tube feeding: Resident #156 was admitted to the facility on [DATE], with multiple diagnoses including stroke and dysphagia (difficulty swallowing). A physician's order, dated 7/8/24, documented Resident #156 was to be placed on enhanced barrier precautions for PEG tube. Gown and gloves required for high-contact patient care (dressing, bathing, transferring, incontinence or toileting care, dressing, changing, linens, or device or wound care). On 8/7/24 at 10:30 AM, observed Resident #156's door to his room, with signage directing staff to wear gloves and a gown for the following high-contact resident care activities: -Dressing -Bathing/showering -Transferring -Changing linens -Providing Hygiene -Changing briefs or assisting with toileting -Device care or use: central line, urinary catheter, feeding tube, tracheostomy -Wound Care: any skin opening requiring a dressing. On 8/7/24 at 12:00 PM, observed RN #2 administer Resident #156's G-tube feeding without donning PPE. On 8/7/24 at 12:19 PM, RN #2 stated he should have donned PPE to give Resident #156 his feeding.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 51121 Based on record review and staff interview, it was determined the facility failed to ensure residents were provided with the pneumococcal vaccine when residents requested it. This was observed in 1 of 5 resident medical records reviewed (Resident #41). This failure created the potential for residents to have an increased risk of pneumococcal (bacterial) pneumonia and the potential for severe illness or death. Findings include: Resident #41 was admitted to the facility 6/19/24, with multiple diagnoses including metabolic encephalopathy (a disturbance of brain function), chronic fatigue, and repeated falls. A review of Resident #41's medical chart showed on admission, Resident #41 requested a pneumonia vaccine. A review of Resident #41's record had no documentation the vaccine had been given. On 8/6/23 at 3:20 PM, the DON stated the pneumonia vaccine had not been given to Resident #41, and there was no documentation in her chart explaining why the vaccine had not been given.