



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

C.L. "BUTCH" OTTER -- Governor  
RICHARD M. ARMSTRONG -- Director

DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

FILE COPY

March 10, 2015

John H. Williams, Administrator  
Oneida County Hospital & Long Term Care Facility  
150 North 200 West, PO Box 126  
Malad, ID 83252-0126

Provider #: 135062

Dear Mr. Williams:

On **February 27, 2015**, a Recertification and State Licensure survey was conducted at Oneida County Hospital & Long Term Care Facility 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 one that comprises a pattern 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 and a similar State Form 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" (listed on page 2). **Please provide ONLY ONE completion date for each federal and state tag 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.

After each deficiency has been answered and dated, the administrator should sign both the Form

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CMS-2567 and State Form, Statement of Deficiencies and Plan of Correction in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 23, 2015**. Failure to submit an acceptable PoC by **March 23, 2015**, may result in the imposition of civil monetary penalties by **April 13, 2015**.

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 both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

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 **April 3, 2015 (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 **April 3, 2015**. A change in the seriousness of the deficiencies on **April 3, 2015**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **April 3,**

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2015 includes the following:

Denial of payment for new admissions effective **May 27, 2015**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, 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 **August 27, 2015**, if substantial compliance is not achieved by that time.

**Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, CMS will provide you with a separate formal notification of that determination.**

If you believe these deficiencies have been corrected, you may contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, Option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **February 27, 2015** 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 noncompliance 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>

go to the middle of the page to **Information Letters** section and click on **State** and select the following:

John H. Williams, Administrator

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- BFS Letters (06/30/11)

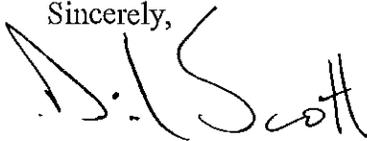
2001-10 Long Term Care Informal Dispute Resolution Process

2001-10 IDR Request Form

This request must be received by **March 23, 2015**. If your request for informal dispute resolution is received after **March 23, 2015**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, Option 2.

Sincerely,

A handwritten signature in black ink that reads "D. Scott". The signature is written in a cursive style with a large, stylized "D" and "S".

DAVID SCOTT, R.N., Supervisor  
Long Term Care

DS/dnj  
Enclosures

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

PRINTED: 03/09/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135062	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  02/27/2015
NAME OF PROVIDER OR SUPPLIER  ONEIDA COUNTY HOSPITAL & LONG TERM CARE FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 150 NORTH 200 WEST MALAD, ID 83252	
(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>The following deficiencies were cited during the annual federal recertification survey of your facility.</p> <p>The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Linda Kelly, RN Kendra Deines RN, BSN</p> <p>The survey team entered the facility on February 23 and exited on February 27, 2015.</p> <p>Survey Definitions: ADL = Activities of Daily Living ADON = Assistant Director of Nursing BIMS = Brief Interview for Mental Status CNA = Certified Nurse Aide DON = Director of Nursing LN = Licensed Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment PRN = As Needed</p>	F 000	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>	
F 241 SS=E	<p><b>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</b></p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility failed to ensure residents were treated with dignity and respect when:</p>	F 241	<p><b>F241</b></p> <p>1.1) A root cause analysis was completed regarding appropriate use of clothing protectors for cognitively impaired residents on 3/17/15. This analysis demonstrated that both residents #12's and #11's care plans indicated that they may choose to have a clothing protector at meals. We found that some staff thought that these documented care plans meant clothing protectors should simply be applied at all meals.</p> <p>1.2) Regarding the use of clothing protectors, all residents have a potential to be affected.</p> <p>1.3) The Director of Nursing (DON) or designee will educate facility staff regarding the need to preserve resident dignity by asking all residents if they desire a clothing protector at mealtime and then honoring the resident's wishes as indicated in the care plan that the resident may choose to have a clothing protector at mealtime. The DON or designee will conduct audits of facility dining services to assure that residents are being asked if they desire a clothing protector at the time of the meal.</p> <p>1.4) To assure compliance, the DON, or</p>	3/31/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: James W. WARD TITLE: Nursing Home Administrator (X6) DATE: 3/20/15

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 241	<p>Continued From page 1</p> <p>*Staff placed clothing protectors on two residents without their permission; *A resident was given medications after a meal had begun; and, *A resident was given medications during an activity, which interrupted the activity for all the residents who participated.</p> <p>This was true for 1 of 12 sampled residents (# 9), two random residents (#11 &amp; 12) and nine other residents in an activity. This practice created the potential to negatively affect the residents' self-worth and self-esteem. Findings included:</p> <p>1. a. Resident #12 was readmitted to the facility on 3/30/07 with multiple diagnoses including dementia with behavioral disturbance.</p> <p>The resident's impaired cognitive care plan, dated 9/30/13, documented an intervention of, "Provide [Resident #12] with a homelike environment. Honor [Resident #12's] choices." The resident's nutrition care plan, dated 10/2/13, documented an intervention of, "[Resident #12] may choose to wear a clothing protector at meals."</p> <p>On 2/24/15 at 12:10 PM, during the lunch observation, CNA #1 was observed to place a clothing protector on Resident #12 without talking to the resident or asking the resident's permission.</p> <p>On 2/24/15 at 5:38 PM, during the dinner observation, a staff member asked Resident #12 if she wanted a clothing protector and the resident stated, "No." However, at 5:48 PM a different staff member (CNA #2) placed a clothing protector on Resident #12 without talking to the resident or asking the resident's permission.</p>	F 241	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>designee, will conduct audits of the facility's dining services daily for two weeks, then three times per week for two weeks, then weekly for one month. These audits will be reviewed at the facility's monthly Quality Assurance Committee (QAC) meeting. Progress and trending related to this deficiency will be monitored by the QAC. If the QAC determines that further monitoring is necessary, audits will continue per the QAC's recommendations. Two sets of the QAC minutes related to this deficiency will be retained by the Nursing Home Administrator (NHA), or designee.</p> <p>1.5) Compliance will be established by 3/31/15. Auditing will continue as indicated to assure ongoing compliance.</p> <p>2&amp;3.1) A root cause analysis was completed regarding appropriate administration of medications during mealtimes and activities on 3/17/15. This analysis demonstrated that in the interest of maintaining compliance with timely medication administration, some staff felt pulling residents (specifically residents #11 and #9) away from meals and/or activities was necessary. Facility staff was immediately instructed not to interrupt resident meals and/or activities for the delivery of medications.</p>	

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F 241	<p>Continued From page 2</p> <p>b. Resident #11 was readmitted to the facility on 7/2/09 with multiple diagnoses including paranoid schizophrenia.</p> <p>The resident's impaired cognitive care plan, dated 11/5/13, documented an intervention of, "Provide [Resident #11] with a homelike environment. Honor her choices." The resident's nutrition care plan, dated 8/5/13, documented an intervention of, "[Resident #11] may choose to wear a clothing protector at meals."</p> <p>On 2/24/15 at 12:05 PM, during the lunch observation, CNA #1 was observed to place a clothing protector on Resident #11 without talking to the resident or asking the resident's permission.</p> <p>On 2/26/15 at 10:55 AM, the ADON was interviewed. When informed about the observations, she stated, "The CNAs need to be reoriented to the care plan." She said the residents needed to be offered a choice.</p> <p>On 2/26/15 at 4:00 PM, the Administrator and DON were informed of the clothing protector issues. No further information was provided by the facility.</p> <p>2. On 2/24/15 at 8:57 a.m., during the breakfast meal service in the dining room, LN #4 was observed as she interrupted Resident #11's meal to administer 10 oral medications, including Miralax in water. The medication administration took approximately 5 minutes to complete. Seven other residents were still eating breakfast at the time of the interruption.</p>	F 241	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>2&amp;3.2) Regarding the interruption of meals and activities for the delivery of medications, all residents have a potential to be affected.</p> <p>2&amp;3.3) The DON or designee will conduct facility wide education of facility staff regarding the need to preserve resident dignity by allowing residents to finish their meals and activities without interruption. If, however, a resident specifically requests an interruption related to the delivery of medications or other issues, staff is expected to honor the resident's specific request provided the request does not interfere with the activities or meals of other residents. If such interference is an issue, the resident requesting assistance will be taken to a private area, and the activity or meal will continue for other residents. The DON or designee will conduct audits of facility practices related to medication passes and the delivery of care during mealtimes and activities.</p> <p>2&amp;3.4) To assure compliance, the DON, or designee, will conduct audits of the facility's practices related to medication passes and the delivery of care during mealtimes and activities daily for two weeks, then three</p>		

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F 241	<p>Continued From page 3</p> <p>Review of Resident #11's care plan did not include any entries regarding medication administration during meals.</p> <p>At 9:05 a.m., LN #4 was interviewed about the administration of Resident #11's medications (meds) during a meal. The LN said Resident #11 "normally gets them before" breakfast and "I asked her if it was okay to give her meds during breakfast and she said, "Yes." The LN explained that she fell behind schedule because she had to administer another resident's medications before that resident left the facility.</p> <p>3. On 2/24/15 at 10:15 a.m., LN #5 was observed as she asked Resident #9 if she could interrupt Bingo activity and take the resident to her room to administer a fentanyl patch. The resident said, "Yes." The LN informed the other 9 residents playing Bingo, "Hold on, it'll just take a few minutes." The LN then wheeled Resident #9 to her room.</p> <p>On 2/24/15 at 10:35 a.m., LN #5 interrupted the Bingo activity again when she asked Resident #9 if it was "okay" to give her her thyroid medication. The resident said, "Yes," and the LN administered the medication while the resident sat at the table with the 9 other residents in the Bingo activity.</p> <p>Immediately afterward, LN #5 was asked about the interruptions to administer medications. The LN stated, "It's okay because she said, "Yes.""</p> <p>On 2/26/15 at 4:00 p.m., the Administrator and DON were informed of the issue. The facility did not provide any other information regarding the issue.</p>	F 241	<p>times per week for two weeks, then weekly for one month. The audits will be reviewed at the facility's monthly QAC meeting. Progress and trending related to this deficiency will be monitored by the QAC. If the QAC determines that further monitoring is necessary, audits will continue per the QAC's recommendations. Two sets of the QAC minutes related to this deficiency will be retained by the NHA, or designee.</p> <p>2&amp;3.5) Compliance will be established by 3/31/15. Auditing will continue as indicated to assure ongoing compliance.</p>		

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F 252 F 252 SS=D	Continued From page 4 483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT  The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.  This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure offensive odors were not present inside a resident's room. This was true for 1 out of 9 sampled residents (#2). This had the potential to decrease the quality of life of the resident. Findings included:  On 2/23/15 at 2:50 PM and on 2/24/15 at 9:00 AM, 11:57 AM, and 1:45 PM, a strong urine odor was detected coming from Resident #2's room.  On 2/24/15 at 11:25 AM, Housekeeper #3 was asked about cleaning routines and she said all resident rooms (which included Resident #2's room) had been cleaned that morning.  On 2/24/15 at 1:50 PM, the Housekeeping Supervisor was interviewed in the resident's room about the urine smell. When asked what he smelled, he stated, "Urine." He then moved about the room to determine where the source of the odor.  On 2/24/15 between 3:00 PM and 4:00 PM, the Administrator provided a root cause analysis document and an update to the document, which outlined the facility plan to address the issue. He	F 252 F 252	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>  F252 1.1) The Housekeeping Supervisor and NHA assessed resident #2's room on 2/24/15 and conducted a root cause analysis regarding a strong odor of urine in the resident's room. We found that, several unused briefs had been placed beneath the resident's mattress indicating the resident may be changing his own briefs possibly without conducting appropriate peri-care. These were found during the room clean on 2/24/15. Through the ongoing root cause investigation, we later (3/2/15) discovered that the resident had urinated into the garbage can in his room. We also discovered that resident #2's shoes were wet and smelled of urine. The DON, or designee, will assess the resident to see if any other clinical factors may be contributing to this issue. If indicated, specialized toileting training will be provided by the nursing staff for this resident. Also, the Housekeeping Supervisor and the NHA conducted a facility wide sweep of all resident rooms and common areas to determine if persistent or lingering odors were present elsewhere in the facility. No other areas were identified as having persistent or lingering odors. Resident #2's room was deep cleaned immediately and the floors in this room were stripped and waxed.	3/31/15

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F 252	Continued From page 5 also stated the resident had been temporarily moved, so housekeeping could strip and wax the floor.  On 2/26/15 at 10:50 AM, the resident was observed back in his original room and the room, which was free of foul odors.	F 252	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.  This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, it was determined the facility failed to revise and update care plans for 2 of 6 sample residents (#s 1 and 2), which created	F 280	1.2) All residents have a potential to be affected.  1.3) The Housekeeping Supervisor, or designee, will educate facility staff regarding appropriate deep cleaning techniques including but not limited to the identification and elimination of persistent or lingering odors. The Housekeeping Supervisor or designee will monitor this process and will report findings to the Quality Assurance Committee (QAC) monthly and as needed until a lesser frequency is deemed appropriate.  1.4) To assure compliance, the NHA, or designee, will conduct environmental audits daily for two weeks, then three times per week for two weeks, then weekly for one month. The audits will be reviewed at the facility's monthly QAC meeting. Progress and trending related to this deficiency will be monitored by the QAC. If the QAC determines that further monitoring is necessary, audits will continue per the QAC's recommendations. Two sets of the QAC minutes related to this deficiency will be retained by the NHA, or designee.  1.5) Compliance will be established by 3/31/15. Auditing will continue as indicated to assure ongoing compliance.		

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F 280	<p>Continued From page 6</p> <p>the potential for more than minimal harm when the residents' care plans did not reflect their current status to ensure the appropriate provision of care Findings included:</p> <p>1. Resident #1 was admitted to the facility in 2009 with multiple diagnoses including unspecified congestive heart failure (CHF), anorexia, and other anxiety state. On 2/8/15, hospice care was started for unspecified hypertensive chronic kidney disease.</p> <p>The resident's 2/10/15 significant change MDS coded total assistance was needed for bed mobility, transfers, and eating.</p> <p>The resident's potential for dehydration/fluid deficit care plan, revised 9/18/14, included the 9/20/13 intervention, "Ensure [resident's name] has access to cold water, or fluid she requests, whenever possible."</p> <p>The resident's ADL self-care performance deficit care plan, however, included a 2/9/15 intervention, "...needs more assist with dining activity in her bed such as holding glass or bites of food..."</p> <p>On 2/23/15 at 3:05 p.m., the resident was observed in bed and her glass of water and Ensure were on the over bed table at the end of the bed. When asked if she could reach the liquids, the resident said "They [staff] will help me. I get all I want."</p> <p>On 2/24/15 at 9:40 a.m., the resident was again observed in bed and her glass of water was on the over bed table at the end of the bed. CNA #8 was in attendance and she offered the water then</p>	F 280	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <hr/> <p><b>F280</b></p> <p>1&amp;2.1) A root cause analysis was conducted to determine why prior care plan preferences and/or orders were allowed to remain on the care plan following care plan updates. We found that in the cited instances for both resident #1 and resident #2, care plan instructions were appropriately updated but prior potentially conflicting instructions were left on the care plans. We found that these were the direct result of staff error.</p> <p>1-2.2) All residents have a potential of being affected.</p> <p>1-2.3) A full sweep of resident care plans will be conducted by the DON, or designee, to assure that all current care plans are updated and reflective of each resident's current needs and that prior preferences and/or orders have been removed from the resident's care plan. The DON, or designee, will monitor resident care plans and will report findings to the QAC monthly and as needed until a lesser frequency is deemed appropriate.</p>	3/31/15	

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F 280	<p>Continued From page 7</p> <p>assisted/held the glass and straw while the resident drank.</p> <p>On 2/26/15 at 10:30 a.m., the DON was asked about the resident's care plan for access to water/other liquids and informed of the observations of the water glass/other liquids on the over bed table at the foot of the resident's bed. The DON said the care plan should have been revised because the resident had grown weaker and, "She can't hold it in bed now."</p> <p>2. Resident #2 was admitted to the facility 6/30/14, and readmitted 7/16/14, with multiple diagnoses, including dementia with behavior disturbance, unspecified alcohol dependence and tobacco use disorder.</p> <p>The resident's 7/13/14 discharge/return anticipated MDS coded wandering behavior occurred 1 to 3 days in the previous 2 weeks. However, wandering behavior was not coded on the subsequent 10/7/14, 10/28/14, and 1/27/15 MDS assessments.</p> <p>The resident's care plan identified "elopement risk/wanderer" as a focus area on 7/3/14. Interventions included: * "Wander guard on ankle at all times. High elopement/wandering risk, R/T [related to] elopement on 10/9/14. Keep in eye sight. Monitor location every 15 min. [minutes]...At times [resident's name] try's [sic] to open doors..." Initiated 10/9/14, revised 12/27/14; * "[Resident's name] likes to go for walks outside. [Resident's name] has agreed to ask to walk with staff...may go out to walk with staff/cane/cell phone..." Initiated 11/20/14; and, * "If anxious talk with [resident's name] offer</p>	F 280	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1-2.4) To assure compliance, the DON, or designee, will conduct care plan audits daily for two weeks, then three times per week for two weeks, then weekly for one month. The audits will be reviewed at the facility's monthly QAC meeting. Progress and trending related to this deficiency will be monitored by the QAC. If the QAC determines that further monitoring is necessary, audits will continue per the QAC's recommendations. Two sets of the QAC minutes related to this deficiency will be retained by the NHA, or his designee.</p> <p>1-2.5) Compliance will be established by 3/31/15. Auditing will continue as indicated to assure ongoing compliance.</p>		

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F 280	Continued From page 8 coffee, soup, sandwich or music, conversation..." Initiated 11/29/14, revised 12/27/14.  On 2/26/15 at 1:15 p.m., the DON was asked about the care plan for monitoring the resident every 15 minute. The DON said the resident eloped in October 2014 but every 15 minute monitoring was no longer needed because the resident had agreed for staff to go on walks with him. She stated, "That's old. We need to take that off."	F 280	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>		
F 328 SS=D	The facility did not provide any other information regarding the care planning issues. 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS  The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.  This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interviews, it was determined the facility failed to ensure oxygen (O2) was administered at the physician-ordered liter flow rate for 2 of 4 residents (#s 1 and 7) reviewed for O2 therapy. This deficient practice created the	F 328	<b>F328</b> 1&2.1) A root cause analysis was conducted to determine if variances between the oxygen (O2) liter flow orders and actual O2 administration for residents #1 and #7 were the result of staff error or a mechanical problem. We found that our liter flow identifiers are comprised of a bubble type identifier that creates a potential for subjective readings by staff. This presented the need for special training of staff regarding assuring O2 flows are accurate. A full sweep of resident O2 levels was conducted by the DON to assure that all residents utilizing wall O2 were receiving the appropriate O2 levels per physician orders.  1&2.2) All residents utilizing wall oxygen have a potential of being affected.  1&2.3) The DON or designee will educate facility staff regarding the appropriate manner of reading bubble type O2 flow meters to eliminate subjectivity in setting O2		

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F 328	<p>Continued From page 9</p> <p>potential for more than minimal harm should the residents have a drop in oxygen saturation levels causing them to become anxious, confused or experience respiratory distress. Findings included:</p> <p>1. Resident #1 was admitted to the facility in 2009 with multiple diagnoses including unspecified congestive heart failure (CHF), anorexia, and other anxiety state. On 2/8/15, hospice care was started for unspecified hypertensive chronic kidney disease.</p> <p>The resident's "Order Review Report" of active orders for 2/1/15 - 2/28/15 included an order for O2 at 2 liters per nasal cannula and "LN to verify flow and placement every 8 hours."</p> <p>The care plan identified the resident was at risk for cardiac side effects related to CHF on 9/18/13 and included the intervention, "Oxygen settings: 2 L/O2..."</p> <p>On 2/24/15 at 2:30 p.m., Resident #1 was observed in bed with a nasal cannula in place while the DON and CNA #8 provided care. The nasal cannula was connected to the O2 cylinder on the wall. The O2 wall cylinder was set at 1 liter/minute.</p> <p>Immediately afterward, the DON and CNA were asked what the resident's O2 should be. The CNA looked at the wall O2 cylinder then changed it to 2 liters/minute. When asked what the O2 was on, the CNA said, "It was on one." The DON confirmed that the O2 was changed from 1 to 2 liters/minute.</p> <p>2. Resident #7 was admitted to the facility in</p>	F 328	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>flow rates. The DON or designee will monitor O2 flow rates and will report findings to the QAC monthly and as needed until a lesser frequency is deemed appropriate. Additionally, the NHA and the Central Supply Coordinator will find a more precise mechanical O2 flow meter device to replace the bubble type flow meters currently in use and will replace the current flow meters with the upgraded model.</p> <p>1&amp;2.4) To assure compliance, the DON, or designee, will conduct O2 flow rate audits daily for two weeks, then three times per week for two weeks, then weekly for one month. The audits will be reviewed at the facility's monthly QAC meeting. Progress and trending related to this deficiency will be monitored by the QAC. If the QAC determines that further monitoring is necessary, audits will continue per the QAC's recommendations. Two sets of the QAC minutes related to this deficiency will be retained by the NHA, or designee.</p> <p>1&amp;2.5) Compliance will be established by 3/31/15. Auditing will continue as indicated to assure ongoing compliance.</p>		

See 1/20/15 BB

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F 328	<p>Continued From page 10</p> <p>October 2013 with multiple diagnoses including cerebrovascular accident (CVA) with left hemiparesis, chronic pain, peripheral neuropathy, anxiety, and shortness of breath.</p> <p>The resident's "Order Review Report" of active orders for 2/1/15 - 3/31/15 included, "Oxygen 2 liters per nasal cannula. LN to verify placement and flow continuous related to shortness of breath."</p> <p>The care plan identified on 10/14/13 that the resident was at risk for cardiac side effects related to chest pain and hyperlipidemia. The care plan included the intervention, "Oxygen settings: O2 (see MAR)..."</p> <p>On 2/25/15 at 2:05 p.m., Resident #7 was observed awake in bed with a nasal cannula in place. The nasal cannula was connected to a wall O2 cylinder. The wall O2 cylinder was set at 2.5 liters/minute. When asked what the O2 liter flow rate should be, the resident said "Two."</p> <p>On 2/25/15 at 2:08 p.m., LN #5 arrived in the resident's room. When asked what the O2 liter flow rate should be, the LN stated, "Two." The LN was asked to look at the wall O2 cylinder and read the liter flow setting. The LN stated, "Two and a half." The LN adjusted the O2 to 2 liters/minutes.</p> <p>On 2/26/15 at 4:00 p.m., the Administrator and DON were informed of the O2 liter flow rate issue. The facility did not provide any other information regarding the issue.</p>	F 328			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431			

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F 431	Continued From page 11  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.  This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, it was determined the facility failed to	F 431	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>  F431 1.1) A root cause analysis was conducted to determine how a transcription error could occur that would result in different directions being listed on the label distributed from the pharmacy vs. the original physician's order for resident #13. After speaking with the pharmacy, it appears that the errors occurred outside the facility. We also found that the nurses involved in these incidents did not compare the medication label to the MAR prior to administering the medication. The DON or designee will initiate staff training for all nursing staff regarding the five rights of medication administration and specifically address double checking the medication label to the MAR prior to administration.  1.2) All residents have a potential of being affected.  1.3) The DON conducted a full sweep or designee will educate facility nursing staff regarding the five rights of medication administration and specifically address the necessity of double-checking medication labels to the MAR. The DON or designee will monitor medication administration and will report findings to QAC monthly and as needed until a lesser frequency is deemed appropriate.	3/31/15	

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F 431	<p>Continued From page 12</p> <p>ensure pharmacy labels matched physician orders for 2 of 27 medications which affected 1 of 10 residents (#13) during medication pass observations. The resident received the wrong dose of Milk of Magnesia (MOM) related to an inaccurate pharmacy label and could have experienced uncontrolled pain when a scheduled pain medication was labeled "as needed." Findings included:</p> <p>a) On 2/24/15 at 4:10 p.m., LN #6 was observed as she poured 7 oral medications for Resident #13. The medications included the pain medication Tramadol 50 milligrams (mg). The pharmacy label on the Tramadol instructed 2 tablets (100 mg) 3 times a day "as needed" for pain. LN #6 reviewed the Tramadol pharmacy label and stated, "No, it's scheduled." The LN compared the pharmacy label to a 1/21/15 physician's prescription for Tramadol 50 mg 2 tablets TID (three times a day). The prescription did not include "as needed." LN #6 also called the DON for assistance.</p> <p>The DON arrived at 4:20 p.m. The DON reviewed the resident's Tramadol pharmacy label to the physician's order then said she would contact the pharmacy and request a new label.</p> <p>b) On 2/26/15 at 9:40 a.m., LN #7 was observed as she poured 2 oral medications for Resident #13. The medications included the laxative medication MOM. The pharmacy label on the MOM instructed 20 milliliters (ml) by mouth every day as needed and the LN administered MOM 20 ml.</p> <p>On 2/26/15 at 11:35 a.m., the resident's "Order Review Report" of active orders for 2/1/15 -</p>	F 431	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <hr/> <p>1.4) To assure compliance, the DON, or designee, will conduct medication administration audits daily for two weeks, then three times per week for two weeks, then weekly for one month. The audits will be reviewed at the facility's monthly QAC meeting. Progress and trending related to this deficiency will be monitored by the QAC. If the QAC determines that further monitoring is necessary, audits will continue per the QAC's recommendations. Two sets of the QAC minutes related to this deficiency will be retained by the NHA, or designee.</p> <p>1-2.5) Compliance will be established by 3/31/15. Auditing will continue as indicated to assure ongoing compliance.</p>	

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F 431	Continued From page 13 3/31/15 were reviewed. The order for MOM read, "Milk of Magnesia Concentrate Suspension. Give 30 ml by mouth as needed for Constipation Give 30 ml on day 3 no bowel movement."  Immediately afterward, LN #7 was interviewed about the difference in the pharmacy label instructions and the physician's orders for MOM. The LN confirmed that she had administered MOM 20 ml according to the pharmacy label. The LN said she would contact the pharmacy and request a new label.  On 2/26/15 at 4:00 p.m., the Administrator and DON were informed of the pharmacy labeling issue. The facility did not provide any other information regarding the issue.	F 431	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program	F 441	<b>F441</b> 1.1) A root cause analysis was conducted examining the process associated with removing and replacing nasal cannulas without the risk of exposure to infection. We found that in the case identified, the nursing staff was unaware of the fact that resident #1's nasal cannula had touched the floor during cares. When staff coiled the nasal cannula tubing following cares, the cannula came off the floor prior to her seeing the cannula. The nurse did not inspect the nasal cannula or its position in the environment before beginning to coil the tubing and cannula. Cannulas and O2 tubing for all identified residents were replaced with new cannulas and new O2 tubing.  1.2) Regarding the placement of a potentially contaminated nasal cannula, all residents utilizing O2 have a potential of being affected.		

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F 441	<p>Continued From page 14</p> <p>determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure staff kept an oxygen (O2) nasal cannula off the floor and staff performed hand hygiene after incontinence care for 1 of 6 sample residents (#1). Failure to follow standard infection control measures created the potential for the resident to develop infection related to cross contamination. Findings included:</p> <p>a) On 2/24/15 at 9:35 a.m., Resident #1 was observed seated in her wheelchair (w/c) in her room with an O2 nasal cannula (NC) in place while CNA #8 and LN #5 prepared to transfer her from the w/c to the bed using a mechanical lift. The CNA removed the resident's O2 NC and handed it to the LN who draped the NC on the left w/c handlebar. However, as the LN and CNA</p>	F 441	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1.3) The DON or designee will initiate staff training for all nursing and nurse aide staff regarding the safe procurement of nasal cannulas and O2 tubing during cares and the assessment of nasal cannulas and O2 tubing prior to re-application. The DON or designee will monitor O2 administration during resident cares and will report findings to the QAC monthly and as needed until a lesser frequency is deemed appropriate.</p> <p>1.4) To assure compliance, the DON, or designee, will conduct O2 administration audits daily for two weeks, then three times per week for two weeks, then weekly for one month. The audits will be reviewed at the facility's monthly QAC meeting. Progress and trending related to this deficiency will be monitored by the QAC. If the QAC determines that further monitoring is necessary, audits will continue per the QAC's recommendations. Two sets of the QAC minutes related to this deficiency will be retained by the NHA, or his designee.</p> <p>1.5) Compliance will be established by 3/31/15. Auditing will continue as indicated to assure ongoing compliance.</p>	see 1.5 BF	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135062	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  02/27/2015
NAME OF PROVIDER OR SUPPLIER  ONEIDA COUNTY HOSPITAL & LONG TERM CARE FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 150 NORTH 200 WEST MALAD, ID 83252		
(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 441	<p>Continued From page 15</p> <p>hooked up the lift sling to the lift machine, the NC fell to the floor next to the left w/c wheel. After the sling was hooked up to the lift, LN #5 wound up the O2 tubing/NC and disconnected it from the portable tank at the back of the w/c. The LN then moved the O2 tubing/NC, connected the tubing to the wall O2 cylinder and placed the contaminated NC on the bed next to the pillow at the head of the bed.</p> <p>At 9:40 a.m., CNA #1 arrived and took over for LN #5 who left the room moments later. The 2 CNAs completed the w/c to bed transfer then provided incontinence care (see b and c below). After that, CNA #1 was about to place the contaminated NC in the resident's nostrils when the surveyor stopped her and informed her that the NC had been on the floor. CNA #1 stated, "I didn't know that." CNA #1 discarded the contaminated NC, said she would get a new one, and then she left the room. CNA #1 returned minutes later with a new NC, which she applied to the resident's nostrils.</p> <p>On 2/24/15 at 10:35 a.m., LN #5 was interviewed and informed that Resident #1's NC had dropped on the floor before the LN moved it to the wall O2 cylinder. The LN stated, "I didn't see that. Oh, I'm sorry."</p> <p>b) On 2/24/15 at 9:40 a.m., CNA #1 and CNA #8 were observed as they provided incontinence care for Resident #1. CNA #1 cleansed feces off the resident's rectal area and left buttock then removed her contaminated gloves. However, CNA #1 did not perform any type of hand hygiene before she applied new gloves and assisted CNA #8 to turn the resident to the opposite side in order for CNA #8 to cleanse the resident's right</p>	F 441	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>2.1) A root cause analysis related to hand washing during cares for resident #1 was conducted. We found that CNA #1 and CNA #8 were aware of the proper hand washing technique but did not wash their hands as previously instructed. A random sampling of CNA's was conducted. All sampled CNA's appropriately demonstrated proper hand washing technique as related to this scenario.</p> <p>2.2) All residents have a potential of being affected.</p> <p>2.3) The DON or designee will initiate staff training for all nursing and nurse aide staff regarding the proper hand washing technique especially as it relates to incontinent care. The DON or designee will monitor hand washing techniques during resident cares and will report her findings to the QAC monthly and as needed until a lesser frequency is deemed appropriate.</p> <p>2.4) To assure compliance, the DON, or designee, will conduct hand washing audits daily for two weeks, then three times per week for two weeks, then weekly for one month. The audits will be reviewed at the facility's monthly QAC meeting. Progress and trending related to this deficiency will</p>		

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F 441	<p>Continued From page 16</p> <p>buttock. After that, the CNAs repositioned the resident onto her back and CNA #1 cleansed the resident's perineal area.</p> <p>On 2/24/15 at 2:50 p.m., CNA #1 was informed of the observation of the aforementioned incontinence care for Resident #1 and that hand hygiene was not observed when she changed gloves between cleansing of the resident's rectal/buttock area then the perineal area. CNA #1 stated, "Oh, okay." The CNA confirmed that she had not performed any type of hand hygiene.</p> <p>c) During the same incontinence care observation (see b above), CNA #8 cleansed the Resident #1's right buttock and helped reposition the resident onto her back then removed her gloves. However, CNA #8 did not perform any type of hand hygiene before she assisted CNA #1 to position pillows under the resident's lower extremities, filled out some paperwork, picked up the resident's water glass bare handed and held the straw between her bare fingers while the resident took sips, changed the channel on the resident's television, picked up the trash and used linens, then left the resident's room with the trash bag and used linens in hand.</p> <p>On 2/24/15 at 2:35 p.m., CNA #8 was informed of the observation of the aforementioned incontinence care for Resident #1 and that hand hygiene was not observed after she removed her gloves following incontinence care. When informed about the bare handed contact with the resident's water glass and straw, the CNA stated, "There you go." The CNA added, "Thank you, I will do better. I was nervous."</p> <p>On 2/26/15 at 4:00 p.m., the Administrator and</p>	F 441	<p>be monitored by the QAC. If the QAC determines that further monitoring is necessary, audits will continue per the QAC's recommendations. Two sets of the QAC minutes related to this deficiency will be retained by the NHA, or designee.</p> <p>2.5) Compliance will be established by 3/31/15. Auditing will continue as indicated to assure ongoing compliance.</p>		

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F 441	Continued From page 17	F 441	<i>This Plan of Correction is the center's credible allegation of compliance.</i>		
F 514 SS=D	<p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the clinical records were complete and accurate for 2 of 10 residents (#s 1 and 6) whose records were reviewed. The failure created the potential for a negative outcome when Resident #1's hospice records were not available for 17 days after hospice care was started and Resident #6's care plan was inaccurate regarding the use of an antihypertensive medication. Findings included:</p> <p>1. Resident #1 was admitted to the facility in 2009 with multiple diagnoses including unspecified congestive heart failure (CHF), anorexia, and other anxiety state. On 2/8/15, hospice care was</p>	F 514	<p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p><b>F514</b> 1.1) A root cause analysis related to the coordination of care with contracted hospice organizations was conducted as it affected resident #1. We found that while a coordination of care meeting had been conducted and documentation was available from the hospice agency, this agency failed to supply the facility with a copy of this or any of their following documentation/ charting despite having been given a specific chart in which to do so. At the time, this was the only hospice patient in the facility so no other charts were found out of compliance. NHA met with the hospice agency community liason and director from Access Hospice. They agreed to instruct their staff to leave a copy of all patient related documentation in the chart provided by the facility and to instruct their staff that a copy of the completed coordination of care form for each hospice admission will be placed in the provided resident chart and another copy will be given directly to the DON.</p> <p>1.2) All residents receiving hospice services have a potential of being affected.</p>	3/31/15	

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F 514	<p>Continued From page 18</p> <p>started for unspecified hypertensive chronic kidney disease.</p> <p>The resident's 2/10/15 significant change MDS coded hospice care while the most recent quarterly MDS, dated 11/11/14, did not code hospice.</p> <p>A 2/5/15 Physician's Order Sheet documented failure to thrive, significant weight loss, and renal disease with the verbal order, "Admit to [name of hospice provider]."</p> <p>The resident's care plan included the focus area, "[Resident's name] and...[family member] choose palliative care/hospice." The focus area was revised 2/8/15 and included the intervention, "Admit to [name of hospice provider], as ordered..."</p> <p>Review of the resident's clinical record revealed there were no hospice documents and no coordinated plan of care between the hospice provider and facility in the chart.</p> <p>On 2/26/15 at 9:00 a.m., the Administrator and DON were asked to provide Resident #1's hospice documentation and hospice provider/facility coordinated plan of care.</p> <p>On 2/26/15 at 10:00 a.m., the DON provided a 68 page stack of documents from the hospice provider which included a cover page and 67 pages of documentation. All of the pages contained a facsimile (fax) date stamp of 2/25/15. The documentation included the hospice's Initial Orders, Plan of Care, IDG (interdisciplinary group) Meeting notes, and IDT (interdisciplinary team) visit notes. However, a coordinated plan of</p>	F 514	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1.3) The DON or designee will initiate staff training for all nursing staff regarding the coordination of care with hospice agencies and the processes for assuring hospice agencies are providing appropriate documentation following their visits. The DON or designee will monitor hospice documentation for all hospice residents and will report her findings to the QAC monthly and as needed until a lesser frequency is deemed appropriate.</p> <p>1.4) To assure compliance, the DON, or designee, will conduct hospice documentation audits daily for two weeks, then three times per week for two weeks, then weekly for one month. The audits will be reviewed at the facility's monthly QAC meeting. Progress and trending related to this deficiency will be monitored by the QAC. If the QAC determines that further monitoring is necessary, audits will continue per the QAC's recommendations. Two sets of the QAC minutes related to this deficiency will be retained by the NHA, or designee.</p> <p>1.5) Compliance will be established by 3/31/15. Auditing will continue as indicated to assure ongoing compliance.</p>		

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F 514	<p>Continued From page 19</p> <p>care between the hospice provider/facility was not included in the faxed records. When asked when the facility received the hospice records, the DON stated, "I don't know. I just called them and said send everything you have." The DON was again asked to provide the coordinated plan of care.</p> <p>The 2/25/15 fax date stamp on the aforementioned hospice documents revealed that the facility did not have any hospice records/documents for 17 days after Resident 1's hospice care started.</p> <p>On 2/26/15 at 12:55 p.m., the Administrator was asked to provide the coordinated plan of care between the hospice provider and facility for Resident #1.</p> <p>On 2/26/15 at 1:40 p.m., the Administrator provided a coordinated plan of care between the hospice provider and facility for Resident #1. When asked when the document was received, the Administrator said, "Not until now."</p> <p>Resident #1's hospice care started on 2/8/15; however, the facility did not have any of the hospice records/documentation for 17 days and did not have the coordinated plan of care for 18 days.</p> <p>2. Resident #6 was admitted to the facility 5/16/12 with multiple diagnoses including obesity, congestive heart failure (CHF), chronic airway obstruction, unspecified hypotension, and above the knee amputations to both legs.</p> <p>The resident's 2/1/15 - 2/28/15 "Order Review Report" and MAR both documented, "Carvedilol [generic for Coreg, an antihypertensive</p>	F 514	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>2.1) A root cause analysis related to MDS transcription was conducted. We found that the MDS Coordinator committed a copying error when transcribing information from the physician order to the MDS and mistakenly read "hypotension" when the diagnosis was actually "hypertension." This caused a deviation in the care plan instructions as compared to the Order Review Report and the MAR for resident #6. The resident care plan was updated immediately. A sweep of all other residents' care plans was conducted in which residents' diagnoses were compared to the care plan and side effects from medications were matched up with the correlating medication and related diagnosis. DON and NHA also met with the MDS Coordinator and reviewed the issue.</p> <p>2.2) All residents have a potential of being affected.</p> <p>2.3) The DON or designee will initiate staff training for MDS Coordinator regarding double checking diagnoses to the care plan. The DON or designee will monitor care plan accuracy and will report findings to the QAC monthly and as needed until a lesser frequency is deemed appropriate.</p>		

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F 514	<p>Continued From page 20 medication] tablet 3.125 mg [milligrams] Give 1 tablet by mouth two times a day for hypertension...Hold if pulse is less than 50. Notify MD [physician]." It was started in August 2013.</p> <p>However, the resident's care plan instructions regarding Coreg were to "Hold" the medication if the systolic blood pressure was greater than 110 and/or the diastolic blood pressure was greater than 80.</p> <p>The Nursing 2015 Drug Handbook, documented the indications for carvedilol (Coreg) were: hypertension, left ventricular dysfunction after MI (heart attack), mild to severe heart failure, chronic but stable angina, and idiopathic cardiomyopathy (enlarged heart with unknown cause) and "Adjust-a-dose (for all indications): In patient with pulse rate below 55 beats/minute, reduce dosage." The handbook also noted that the standing blood pressure should be monitored after the first dose and after dosage increases.</p> <p>Regarding hypertension (high blood pressure) and hypotension (low blood pressure), the 2014 8th edition of Clinical Nursing Skills &amp; Techniques by Perry, Potter, and Ostendorf stated, "Hypertension is defined as systolic blood pressure...of 140 mm Hg [milligrams of mercury] or greater, diastolic blood pressure...of 90 mm Hg, or greater..." and "Hypotension occurs when the systolic blood pressure falls to 90 mm Hg or below..."</p> <p>On 2/26/15 at 11:30 a.m., the DON was asked about the difference between Resident #6's orders for Coreg and the care plan instructions for Coreg. The DON reviewed the orders, MAR, and the care plan then said, "It must be a cut and</p>	F 514	<p>2.4) To assure compliance, the DON, or designee, will conduct care plan accuracy audits daily for two weeks, then three times per week for two weeks, then weekly for one month. The audits will be reviewed at the facility's monthly QAC meeting. Progress and trending related to this deficiency will be monitored by the QAC. If the QAC determines that further monitoring is necessary, audits will continue per the QAC's recommendations. Two sets of the QAC minutes related to this deficiency will be retained by the NHA, or designee.</p> <p>2.5) Compliance will be established by 3/31/15. Auditing will continue as indicated to assure ongoing compliance.</p>	

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F 514	Continued From page 21 paste thing. The care plan is wrong. We will change it."	F 514			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MDS001570	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  02/27/2015
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C 000	16.03.02 INITIAL COMMENTS  The following deficiencies were cited during the State licensure survey of your facility.  The surveyors conducting the survey were: Brad Perry, BSW, LSW, Team Coordinator Linda Kelly, RN Kendra Deines RN, BSN	C 000		
C 664	02.150.02,a Required Members of Committee  a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on review of Infection Control Committee (ICC) meeting minutes, attendance records, and policy and staff interview, it was determined the facility failed to ensure the Medical Director participated in quarterly ICC meetings and that the facility's ICC policy included the Medical Director in those meetings. The failures created the potential for negative outcomes for residents, visitors, and staff in the facility. Findings included:  On 2/26/15 at 2:00 p.m., the DON was asked about the facility's infection control program. The Administrator and 2 other surveyors were present. The DON said she and other nursing staff met monthly with the pharmacist to review antibiotic use and other infection control related issue. When asked if other ICC members, such as the Medical Director, attended the monthly meetings, the DON said, "No." The Administrator said that infection control was a part of quarterly department head meetings. The Administrator added, however, that the Medical Director did not	C 664	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>C664 1.1) A root cause analysis was conducted regarding facility staff attendance at quarterly infection control meetings. We found that the facility policies did not require the Medical Director to attend quarterly infection control meetings. This policy was immediately updated to demonstrate compliance with state regulations. The NHA spoke with the current Medical Director and explained the need to have him attend these meetings. The Medical Director agreed to do so without complaint.</p> <p>1.2) All residents have a potential of being affected.</p> <p>1.3) The NHA or designee will schedule and monitor infection control meeting attendance and will report findings to the QAC monthly and as needed until a lesser frequency is</p>	3/21/15

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Nursing Home Administrator	(X6) DATE 4/2/15
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Bureau of Facility Standards

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(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) COMPLETE DATE
C 664	<p>Continued From page 1</p> <p>attend those meetings either. The Administrator was asked to provide the quarterly ICC meeting minutes/attendance records for the previous 2 quarters. He was also asked to provide the facility's ICC policies. The Administrator said he would need to contact the Human Resources (HR) department to get the minutes/attendance records.</p> <p>On 2/26/15 at 3:30 p.m., an HR staff member and the Administrator provided Department Head Meeting Agenda minutes/attendance records for 4/29/14, 7/29/14, and 12/30/14. The HR staff member reviewed the attendance records with the surveyor and identified all ICC members, except the Medical Director. The HR staff member said the physician was not present at any of the meetings.</p> <p>On 2/26/15 at 3:50 p.m., the Administrator stated, "Our policy is wrong," as he provided the facility's 2008 Infection Control Committee policy which included:</p> <ul style="list-style-type: none"> <li>* Purpose: Serves as a multidisciplinary subcommittee of the medical staff, reporting to the Executive Committee..."</li> <li>* "Functions: ...Provide written minutes of meetings or other committee activities to the Executive Committee of the medical staff..."</li> <li>* Composition: ...shall consist of representatives from Administration, Nursing, and medical staff members (as required by the bylaws of the medical staff)..."</li> </ul> <p>The facility did not provide any other information regarding this issue.</p>	C 664	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>deemed appropriate. Attendance for these meetings will be taken at the beginning of the meeting. If any of the required attendees are not present they will be teleconferenced in via phone.</p> <p>1.4) To assure compliance, the NHA, or designee, will conduct infection control audits quarterly for six months. The audits will be reviewed at the facility's monthly QAC meeting. Progress and trending related to this deficiency will be monitored by the QAC. If the QAC determines that further monitoring is necessary, audits will continue per the QAC's recommendations. Two sets of the QAC minutes related to this deficiency will be retained by the NHA, or designee.</p> <p>1.5) Compliance will be established by 3/31/15. Auditing will continue as indicated to assure ongoing compliance.</p>	