



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR  
LICENSING & CERTIFICATION  
DEBBY RANSOM, R.N., R.H.I.T – Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
PHONE: (208) 334-6626  
FAX: (208) 364-1888  
E-mail: [fsb@dhw.idaho.gov](mailto:fsb@dhw.idaho.gov)

September 16, 2016

Chase Gunderson, Administrator  
Owyhee Health & Rehabilitation Center  
PO Box A  
Homedale, ID 83628-2040

Provider #: 135087

Dear Mr. Gunderson:

On **September 9, 2016**, a survey was conducted at Owyhee Health & Rehabilitation Center by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be 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. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct." **Please provide ONLY ONE completion date for each federal and state tag (if applicable) in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

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

Your Plan of Correction (PoC) for the deficiencies must be submitted by **September 26, 2016**. Failure to submit an acceptable PoC by **September 26, 2016**, may result in the imposition of penalties by **October 21, 2016**.

The components of a Plan of Correction as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained; and
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the federal survey report, Form CMS-2567 and the state licensure survey report, State Form (if applicable).

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **October 14, 2016 (Opportunity to Correct)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **December 8, 2016**. A change in the seriousness of the deficiencies on **October 24, 2016**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **December 8, 2016** includes the following:

Denial of payment for new admissions effective **December 8, 2016**. [42 CFR §488.417(a)]

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying non-compliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **March 8, 2017**, 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 **December 8, 2016** and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

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

Chase Gunderson, Administrator  
September 16, 2016  
Page 4 of 4

- 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 **September 26, 2016**. If your request for informal dispute resolution is received after **September 26, 2016**, 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 cursive script that reads "Nina Sanderson LSW".

Nina Sanderson, LSW, Supervisor  
Long Term Care

NS/lj  
Enclosures

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

PRINTED: 10/12/2016  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>135087</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                                                                                        |                      | (X3) DATE SURVEY COMPLETED<br><br><b>09/09/2016</b> |
|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|-----------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>OWYHEE HEALTH &amp; REHABILITATION CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>108 WEST OWYHEE<br/>HOMEDALE, ID 83628</b>                                                                                                      |                      |                                                     |
| (X4) ID PREFIX TAG                                                                   | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID PREFIX TAG                                                           | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)                                                                             | (X5) COMPLETION DATE |                                                     |
| F 000                                                                                | INITIAL COMMENTS<br><br>The following deficiencies were cited during the federal recertification and complaint survey conducted at the facility from September 6, 2016 to September 9, 2016.<br><br>The surveyors conducting the survey were:<br>Brad Perry, BSW, LSW, Team Coordinator<br>David Scott, RN<br>Susan Costa, RN<br>Edith Cecil, RN<br><br>Survey Definitions:<br>BM = Bowel Movement<br>CHF = Congestive Heart Failure<br>CNA = Certified Nurse Aide<br>COPD = Chronic Obstructive Pulmonary Disease<br>DON = Director of Nursing<br>LLQ = Left Lower Quadrant<br>LN = Licensed Nurse<br>MAR = Medication Administration Record<br>MDS = Minimum Data Set assessment<br>PRN = As Needed | F 000                                                                   |                                                                                                                                                                                             |                      |                                                     |
| F 281<br>SS=D                                                                        | 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br><br>The services provided or arranged by the facility must meet professional standards of quality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and record review, it was determined the facility failed to ensure professional standards of practice were followed for 1 of 2 random residents (#11) whose insulin injections were observed during                                                                                                                                                                                                                                 | F 281                                                                   | Corrective Actions:<br>Risk vs. benefit put in place stating each resident's preference to only receive insulin injections in their abdomens. Care plan will be updated to reflect resident | 9/30/16              |                                                     |

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

TITLE

(X6) DATE

Electronically Signed

09/26/2016

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>135087</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                      | (X3) DATE SURVEY COMPLETED<br><br><b>09/09/2016</b> |
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| F 281                                                                                | <p>Continued From page 1 medication pass, and 1 of 9 sampled residents (#2) . This failed practice created the potential for harm when Resident #'s 2 and 11's injection sites were not rotated. Findings include:</p> <p>MERCK Manual stated insulin injections can affect the skin and underlying tissues at the injection site. The Insulin injections may cause fat deposits, making the skin look lumpy, or destroy fat, causing indention of the skin. Changing the site of injection with each dose generally prevents these complications.</p> <p>The facility's Insulin Injections policy and procedure, revised 2007, stated, "Select injection site based on planned site rotation. Rotate insulin injections between the different sites." The facility failed to follow its policy in the examples below:</p> <p>1. Resident #2 was admitted to the facility on 3/17/10, with multiple diagnoses, including Type II insulin dependent diabetes.</p> <p>Resident #2's Order Summary Report, dated 9/1/16, included orders for Levemir Solution 10 units injected subcutaneously at bedtime for diabetes, and Novolog Solution 6 units injected subcutaneously three times daily with meals.</p> <p>Resident #2's August 2016 MAR documented insulin was injected at the same anatomical site for 80 of 123 doses that month, or 65%.</p> <p>Sites of injection to Resident #2's LLQ (lower left quadrant) were documented as follows:</p> <p>- 8/4/16 to 8/7/16: 14 of 16 injections.</p> | F 281                                                                   | <p>preference. Rotation site will be rotated on the abdomen and documented.</p> <p>Identification of others affected:<br/>No other residents were affected.</p> <p>Measures to ensure that the deficient practice does not happen again:<br/>Nurses will be in-serviced on 9/27/16 regarding proper insulin site rotation.</p> <p>Monitor Corrective Actions:<br/>DON or designee will audit residents receiving insulin injections for proper rotation weekly X 8 weeks and monthly X 2 months. Findings will be presented to the QA committee.</p> |                      |                                                     |

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

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| F 281                                                                                | <p>Continued From page 2</p> <ul style="list-style-type: none"> <li>- 8/11/16 to 8/14/16: 13 of 16 injections.</li> <li>- 8/18/16 to 8/21/16: 12 of 16 injections.</li> <li>- 8/25/16 to 8/28/16: 13 of 16 injections.</li> <li>- 8/29/16 to 8/31/16: 7 of 12 injections.</li> </ul> <p>Resident #2's September MAR documented insulin was injected to the LLQ 19 of 32 doses, or 59%, from 9/1/16 to 9/8/16.</p> <p>On 6/6/16 at 9:23 am, the DON stated insulin administration sites should be rotated.</p> <p>Random Resident # 11 was admitted to the facility with a diagnosis of Type II diabetes mellitus. Random Resident #11 had physician orders for Lantus Solution 60 units subcutaneously at bedtime and Humulin R Solution 18 units subcutaneously with meals.</p> <p>On 9/7/16 at 12:01 pm, LN # 1 was observed withdrawing insulin from a vial into a syringe. As she approached Random Resident # 11, he lifted the left front side of his shirt to allow access to his abdominal area. LN # 1 injected the insulin into his LLQ. When asked how the injection site was determined, LN #1 stated, "It is documented on the MAR," and pointed to the documentation on the computer screen of the previous injection to the LLQ.</p> <p>The MAR, dated 9/1/16 through 9/9/16, documented insulin was provided 33 times with 14 of those administrations (42.4%) consecutively injected to Random Resident #11's LLQ.</p> <p>On 9/9/16 at 9:25 am, the DON provided a</p> | F 281                                                                   |                                                                                                                 |                      |                                                     |

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| F 281                                                                                | Continued From page 3<br>policy/procedure for insulin injections and stated, "They [facility nurses] should be rotating sites, it's just good practice."                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | F 281                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                      |                                                     |
| F 309<br>SS=D                                                                        | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, it was determined the facility failed to ensure residents received appropriate bowel care. This was true for 1 of 7 sampled residents and had the potential to cause harm if residents did not receive appropriate treatment for constipation. Findings include:<br><br>1. Resident #2 was admitted to the facility on 3/17/10 with diagnoses that included Type II insulin dependent diabetes and dementia.<br><br>September 2016 Physician's Orders documented Resident #2 was to receive:<br>- Docusate Sodium 100 mg, 2 tablets twice daily.<br>- Sennosides 8.6 mg, 2 tablets daily 3 times daily for constipation.<br>- Dulcolax Suppository 10 gm rectally if no bowel movement for 3 days.<br>- Milk of Magnesia, 30 cc daily PRN for constipation. There was no instruction on the | F 309                                                                   | Corrective Actions<br>Resident 2 has had consistent BMs and has shown no ill effects from not receiving milk of magnesia as ordered.<br><br>Identification of others affected and corrective actions:<br>No other residents were affected.<br><br>Measures to ensure that the deficient practice does not happen again:<br>Current bowel protocol reviewed with medical director and revisions made in bowel protocol to remain consistent with EHR. Alert will be given on the third day and intervention started. Nurses will be in-serviced on 9/27/16 regarding new bowel protocol.<br><br>Monitor corrective actions:<br>DON or designee will audit successful | 9/30/16              |                                                     |

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| F 309                                                                                | <p>Continued From page 4</p> <p>Physican's Order specifying when the Milk of Magnesia should be administered.</p> <p>The August 2016 Bowel Continence record documented Resident #2 did not experience a bowel movement for six days, from 8/10/16 to 8/16/16. The resident did not receive any PRN bowel medications until Milk of Magnesia was administered at 6:31 am on 8/16/16 and a bowel movement was recorded at 9:22 pm. Dulcolax and Milk of Magnesia were not administered as ordered by the resident's physician during the six-day period.</p> <p>Resident #2 did not experience a bowel movement from 8/26/16 to 8/30/16, (4 days). Milk of Magnesia was provided on 8/30/16 at 5:46 am and a bowel movement was recorded later that day. The Milk of Magnesia and Dulcolax were not administered as ordered by the resident's physician.</p> <p>Resident #2 did not experience a bowel movement from 8/31/16 to 9/3/16, (4 days). Milk of Magnesia and Dulcolax were not administered.</p> <p>On 9/9/16 at 9:23 am, the DNS stated the facility's electronic MAR system alerts nurses when a resident has not had a bowel movement beyond 2 days. She stated the nurse must acknowledge the alert before it is cleared from the screen.</p> <p>On 9/9/16 at 9:50 am, LN #2 reviewed Resident #2's record and stated she cleared the alert on 9/2/16 although nurses were supposed to determine whether additional interventions were needed in response to an electronic MAR alert.</p> | F 309                                                                   | <p>implementation of bowel protocol twice weekly X 8 weeks then weekly X 2 months. Findings will be presented to QA committee.</p> |                      |                                                     |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>135087</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                      | (X3) DATE SURVEY COMPLETED<br><br><b>09/09/2016</b> |
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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) COMPLETION DATE |                                                     |
| F 309                                                                                | Continued From page 5<br>LN #2 stated she did not administer Resident #2's Milk of Magnesia or Dulcolax as ordered by the physician.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | F 309                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                      |                                                     |
| F 323<br>SS=E                                                                        | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, it was determined the facility failed to ensure:<br>*Bed canes were assessed as safe for resident use, and<br>*Harmful chemicals were secured safely. This was true for 2 of 9 residents (#2 & #4) sampled for side rail use, and 1 of 3 storage closets in the facility's hallways. This failure created the potential for harm should a resident become entrapped in a device attached to their bed, and for any independently mobile, cognitively impaired resident who could access the unsecured chemicals. Findings included:<br><br>1. Resident #4 was admitted to the facility on 2/23/15 with multiple diagnoses, including dementia and muscle weakness.<br><br>Resident #4's clinical record did not identify the need for side rails and did not contain a side rail safety assessment. | F 323                                                                   | Corrective actions:<br>Side rails removed from the beds of residents 2 and 4.<br><br>Identification of others affected and corrective actions:<br>No other residents were affected.<br><br>Measures to ensure that the deficient practice does not happen again:<br>A safety assessment will be conducted before the placement of side rails on any resident bed. Clinical staff and plant manager will be in-serviced on 9/27/16 regarding the need of a safety assessment before the placement of side rails.<br><br>Monitor Corrective actions:<br>Plant manager or designee will audit side rails in the facility weekly X 6 weeks then | 9/30/16              |                                                     |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                     | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>135087</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X3) DATE SURVEY COMPLETED<br><br><b>09/09/2016</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>OWYHEE HEALTH &amp; REHABILITATION CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>108 WEST OWYHEE<br/>HOMEDALE, ID 83628</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                     |
| (X4) ID PREFIX TAG                                                                   | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID PREFIX TAG                                                                          | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X5) COMPLETION DATE                                |
| F 323                                                                                | <p>Continued From page 6</p> <p>On 9/6/16 at 10:55 am and throughout the survey process, bed cane side rails on both sides of the resident's bed were observed in the upright position.</p> <p>On 9/8/16 at 9:20 am, the DON said Resident #4 did not have a side rail safety assessment because the facility did not consider bed cane side rails a safety hazard as they were there only to hold bed controls.</p> <p>2. Resident #2 was admitted to the facility on 3/17/10 with multiple diagnoses, including insulin dependent Type II diabetes, COPD, CHF, and dementia.</p> <p>Resident #2's clinical record did not identify the need for side rails nor include a side rail safety assessment.</p> <p>During observations on 9/6/16 at 10:00 am and throughout the survey process, Resident #2's bed cane side rails were both observed in the upright position.</p> <p>When a side rail safety assessment was requested on 9/8/16 at 11:20 am, the DON stated Resident #2 did not have an assessment, as the cane side rails were not considered a restraint, but rather an assistive device. She stated the side rails would be removed that day.</p> <p>3. On 9/6/16 at 9:07 am, the storage closet across from resident Room 23 was found to be unlocked. Inside on the shelf was a half full bottle of isopropyl rubbing alcohol that included on its label the following warning: "Flammable ... If</p> | F 323                                                                                  | <p>monthly X 2 months. Results will be presented to the QA committee.</p> <p>Corrective actions:<br/>Rubbing alcohol was removed from the closet.</p> <p>Identification of others affected and corrective actions:<br/>No residents were affected.</p> <p>Measures to ensure that the deficient practice does not happen again:<br/>Staff will be in-serviced on 9/27/16 on the proper storage of harmful chemicals.</p> <p>Monitor corrective actions:<br/>Housekeeping or designee will audit safe storage of harmful chemicals daily X 4 weeks then weekly X 8 weeks. Results will be presented to the QA committee.</p> |                                                     |

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

PRINTED: 10/12/2016  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                     |                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>135087</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                            |                      | (X3) DATE SURVEY COMPLETED<br><br><b>09/09/2016</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>OWYHEE HEALTH &amp; REHABILITATION CENTER</b> |                                                                                                                                                                                                                                                                                                                                                         |                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>108 WEST OWYHEE<br/>HOMEDALE, ID 83628</b>                          |                      |                                                     |
| (X4) ID PREFIX TAG                                                                   | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                  | ID PREFIX TAG                                                           | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |                                                     |
| F 323                                                                                | Continued From page 7<br>swallowed contact Poison Control immediately ...<br>Do not apply to eyes."<br><br>On 9/6/16 at 9:10 am, LN #3 said the isopropyl rubbing alcohol should not have been in an unlocked storage closet. LN #2 then took the bottle from LN #3, drained the alcohol down a sink in the nurses station, and disposed of the bottle. | F 323                                                                   |                                                                                                                 |                      |                                                     |

Bureau of Facility Standards

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>MDS001660</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>09/09/2016</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>OWYHEE HEALTH &amp; REHABILITATION CENTER</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>108 WEST OWYHEE<br/>HOMEDALE, ID 83628</b> |
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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 |
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| C 000              | <p>16.03.02 INITIAL COMMENTS</p> <p>The following deficiencies were cited during the State licensure survey of your facility.</p> <p>The surveyors conducting the survey were:<br/>Brad Perry, BSW, LSW, Team Coordinator<br/>David Scott, RN<br/>Suzi Costa, RN<br/>Edith Cecil, RN</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | C 000         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                    |
| C 422              | <p>02.120,05,p,vii Capacity Requirments for Toilets/Bath Areas</p> <p>vii. On each patient/resident floor or nursing unit there shall be at least one (1) tub or shower for every twelve (12) licensed beds; one (1) toilet for every eight (8) licensed beds; and one (1) lavatory with mirror for every eight (8) licensed beds. Tubs, showers, and lavatories shall be connected to hot and cold running water.</p> <p>This Rule is not met as evidenced by:<br/>Based on observation and staff interview, it was determined the facility did not provide one tub or shower for every 12 licensed beds. Findings included:</p> <p>On 9/8/16, the Maintenance Supervisor acknowledged the facility was licensed for 49 beds, however the building's two tubs and one shower met the requirement for only 36 beds.</p> <p>On 9/9/16 at 110:30 am, the Administrator requested to continue a waiver for the bathing facilities.</p> | C 422         | <p>This facility requests the continuance of the waiver that has existed for many years in this facility.</p> <p>We are short two shower/bath rooms. To ensure it does not negatively affect our residents we employ dedicated bath aides to ensure that all showers and baths are scheduled and executed for each resident according to their choice and preference. We talk about it at resident council and survey residents to verify outcomes are positive. No residents have been negatively affected by the number of shower rooms.</p> | 9/30/16            |

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| Bureau of Facility Standards<br>LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE<br><br>Electronically Signed | TITLE | (X6) DATE<br><b>09/26/16</b> |
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Bureau of Facility Standards

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>MDS001660</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>09/09/2016</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>OWYHEE HEALTH &amp; REHABILITATION CENTE</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>108 WEST OWYHEE<br/>HOMEDALE, ID 83628</b> |
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|--------------------|------------------------------------------------------------------------------------------------------------------------|---------------|-----------------------------------------------------------------------------------------------------------------|--------------------|
| C 422              | Continued From page 1                                                                                                  | C 422         | We are licensed for 49 beds but our ADC last year was 31.                                                       |                    |