February 23, 2018

John Williams, Administrator
Oneida County Hospital & Long Term Care Facility
Po Box 126
Malad, ID 83252-0126

Provider #: 135062

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Williams:

On February 13, 2018, a Facility Fire Safety and Construction survey was conducted at Oneida County Hospital & Long Term Care Facility by the Department of Health & Welfare, 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 Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide ONLY ONE completion date for each federal and state tag in column (XS) Completion Date to signify when
you allege that each tag will be back in compliance. **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). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **March 8, 2018.** Failure to submit an acceptable PoC by **March 8, 2018,** may result in the imposition of civil monetary penalties by **March 28, 2018.**

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;

- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,

- Include dates when corrective action will be completed.

- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567. If a State Form was issued as well, it should also be signed, dated and returned.

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

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by, (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. A change in the seriousness of the deficiencies on, may result in a change in the remedy.

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

Denial of payment for new admissions effective.
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 [date], 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, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; Fax #: (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 13, 2018, 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:

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

BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **March 8, 2018.** If your request for informal dispute resolution is received after **March 8, 2018,** 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, please contact us at (208) 334-6626, option 3.

Sincerely,

Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE
Enclosures
The facility is a single story, Type III (211) building with basement completed in November 1970 and an addition completed in 1993. There is an attached Critical Access Hospital. The facility currently has a two-hour rated fire barrier which divides the structure, but does not create a separation between the CAH and the LTC sections of the building. Currently, the Nursing Facility is licensed for 33 beds.

The facility was found to be in substantial compliance during the annual fire/life safety survey conducted on February 13, 2018. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 485.623.

The Survey was conducted by:

Sam Burbank  
Health Facility Surveyor  
Facility Fire Safety and Construction

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<td>The facility is a single story, Type III (211) building with basement completed in November 1970 and an addition completed in 1993. There is an attached Critical Access Hospital. The facility currently has a two-hour rated fire barrier which divides the structure, but does not create a separation between the CAH and the LTC sections of the building. Currently, the Nursing Facility is licensed for 33 beds. The facility was found to be in substantial compliance during the annual fire/life safety survey conducted on February 13, 2018. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 485.623. The Survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</td>
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**Laboratory Director's or Provider/Supplier Representative's Signature:**

**Title:**

**Date:**

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

| (XX) Provider/Supplier/Clinic Identification Number: | 135062 |
| (X11) Name of Provider or Supplier: | ONEIDA COUNTY HOSPITAL & LONG TERM CARE |
| Street Address, City, State, Zip Code: | 150 NORTH 200 WEST MALAD, ID 83252 |
| Name of Provider or Supplier: | ONEIDA COUNTY HOSPITAL & LONG TERM CARE |
| Street Address, City, State, Zip Code: | 150 NORTH 200 WEST MALAD, ID 83252 |

### Summary Statement of Deficiencies

#### E 000 Initial Comments

The facility is a single story, Type III (211) building with a partial basement completed in November 1970, with an addition completed in 1993 and an attached Critical Access Hospital. The facility currently has a two-hour rated fire barrier which divides the structure, but does not create a separation between the CAH and the LTC sections of the building. The facility is located in a rural fire district, and utilizes information as provided in the Bannock County All Hazards Mitigation plan. The facility is currently licensed for 33 SNF/NF beds.

The following deficiencies were cited during the Emergency Preparedness survey conducted on February 13, 2018. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.

The Survey was conducted by:

Sam Burbank
Health Facility Surveyor
Facility Fire Safety and Construction

#### E 007 Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths of the facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it.

- **Corrective action for Identified areas/residents.**
  - The Nursing Home Administrator (NHA) created a Clinical Admission Grid that demonstrates the types of services the facility is able to provide to provide to outside agencies and persons at risk during emergency situations. Facility policies and procedures related to admissions and discharges were updated to include the implementation and use of the Clinical Admission Grid when accepting transfers and admissions from other facilities.
  - Identification of residents with potential to be affected.
  - All residents and patients have the potential to be affected.
  - Measures to prevent occurrence.
  - The facility's Clinical Admission Grid will be implemented immediately. Facility staff normally involved in accepting or approving transfers and admissions were educated regarding the use of the Clinical Admission Grid on 3/7/2018. Other facility staff will be educated regarding the use of the Clinical Admission Grid on 3/7/2018 at our employees forum.
  - **Monitoring and Quality Assurance.**
    - The LCSW, or designee, will conduct a weekly audit demonstrating that the Clinical Admission Grid is being referenced prior to facility admissions. This audit will be reported to the NHA weekly for four weeks.

### Provider's Plan of Correction

**Summary Statement of Deficiencies**

- DEFICIENCY: 483.73(a)(3) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:
  - Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.

**E 007 Corrective Action**

The facility's Clinical Admission Grid will be implemented immediately. Facility staff normally involved in accepting or approving transfers and admissions were educated regarding the use of the Clinical Admission Grid on 3/7/2018. Other facility staff will be educated regarding the use of the Clinical Admission Grid on 3/7/2018 at our employees forum.

**E 008 Identifying residents with potential to be affected.**

- All residents and patients have the potential to be affected.

**E 009 Measures to prevent occurrence.**

- The facility's Clinical Admission Grid will be implemented immediately. Facility staff normally involved in accepting or approving transfers and admissions were educated regarding the use of the Clinical Admission Grid on 3/7/2018. Other facility staff will be educated regarding the use of the Clinical Admission Grid on 3/7/2018 at our employees forum.

**E 010 Monitoring and Quality Assurance.**

- The LCSW, or designee, will conduct a weekly audit demonstrating that the Clinical Admission Grid is being referenced prior to facility admissions. This audit will be reported to the NHA weekly for four weeks.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:

135062

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED

02/13/2018

NAME OF PROVIDER OR SUPPLIER
ONEIDA COUNTY HOSPITAL & LONG TERM C

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)

ID PREFIX TAG

COMPLETION DATE

E 007 Continued From page 1.

*Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.]
This REQUIREMENT is not met as evidenced by:
Based on record review, it was determined the facility failed to provide an emergency plan, policies and procedures, addressing the types of support services the facility was able to provide to outside agencies during an emergency. Failure to provide information as to the types of services the Long Term Care (LTC) facility is able to provide, potentially hinders surge capabilities and continuation of resident care during a disaster. This deficient practice potentially affected 24 residents, staff and visitors on the date of the survey.

Findings include:

On 2/13/18 from 9:00 AM - 3:00 PM, review of provided emergency plan, policies and procedures, failed to demonstrate the types of services the facility would be able to provide either to outside agencies or persons at-risk during an emergency.

Reference:
42 CFR 483.73 (a) (3)

E 015 Subsistence Needs for Staff and Patients

SS=C CFR(s): 483.73(b)(1)

[(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and
E 015 Continued From page 2
procedures must be reviewed and updated at
least annually.] At a minimum, the policies and
procedures must address the following:

(1) The provision of subsistence needs for staff
and patients whether they evacuate or shelter in
place, include, but are not limited to the following:
   (i) Food, water, medical and pharmaceutical
   supplies
   (ii) Alternate sources of energy to maintain the
       following:
       (A) Temperatures to protect patient health
           and safety and for the safe and sanitary storage of
           provisions.
       (B) Emergency lighting.
       (C) Fire detection, extinguishing, and alarm
           systems.
       (D) Sewage and waste disposal.

*[For Inpatient Hospice at §418.113(b)(6)(iii):]

Policies and procedures.

(2) The following are additional requirements for
hospice-operated inpatient care facilities only.
The policies and procedures must address the
following:
   (ii) The provision of subsistence needs for
       hospice employees and patients, whether they
       evacuate or shelter in place, include, but are not
       limited to the following:
       (A) Food, water, medical and pharmaceutical
           supplies.
       (B) Alternate sources of energy to maintain the
           following:
           (1) Temperatures to protect patient health
               and safety and for the safe and sanitary storage of
               provisions.
           (2) Emergency lighting.
           (3) Fire detection, extinguishing, and alarm
               systems.
           (C) Sewage and waste disposal.

Corrective action for Identified
areas/residents.

On 3/5/2018 a facility policy was created
that addresses when evacuation will become
necessary related to an inability to provide
sewage and waste disposal for residents and
staff while sheltering in place during a
disaster. The policy specifically defines the
location of alternate storage sites for bio-
material, paper waste, and other articles of
waste. The policy also defines emergency
disposal of sewage and alternate options for
sewage containment during an emergency.
The policy defines the point at which waste
build-up requires evacuation to external
entities.

Identification residents with potential to
be affected.

All residents and patients have the
potential to be affected.

Measures to prevent occurrence.

A mandatory employee forum was
scheduled for 3/27/2018. Facility staff will be
educated regarding the updated Emergency
Sewage and Waste Disposal policy during
the employee forum.

Monitoring and Quality Assurance

The NHA, or designee, will conduct
education regarding the facility's Emergency
Response Plan (ERP) on 3/27/2018. This
ERP education will include education
regarding the facility's evacuation policies
specific to sewage and waste and when it is
necessary to evacuate to an external entity.
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<td>This REQUIREMENT is not met as evidenced by:</td>
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<td>Based on record review, the facility failed to provide an emergency plan, policy and procedures that ensure sewage and waste disposal was provided in the event of sheltering in place. Failure to provide sewage and waste disposal in the event of a disaster has the potential to limit the facility's ability of providing safe and sanitary continuity of care in an emergency. This deficient practice affected 24 residents, staff and visitors on the date of the survey.</td>
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<td>Findings include:</td>
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<td>Review of provided emergency plan, policies and procedures for the facility conducted on 2/13/18 from 9:00 AM - 3:00 PM, did not indicate the ability of the facility to provide sewage and waste disposal for residents and staff while sheltering in place during a disaster.</td>
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<td>Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2)</td>
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<td>[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:] (2) A system to track the location of on-duty staff</td>
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**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**[X1] PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:**

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**E 018**

and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location.

**[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IID at §483.475(b), PACE at §460.84(b):]**

Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location.

**[For Inpatient Hospice at §418.113(b)(6):]**

Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance.

(v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location.

**[For CMHCs at §485.920(b):]**

Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of

**[X2] MULTIPLE CONSTRUCTION:**

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**[X3] DATE SURVEY COMPLETED:**

**02/13/2018**

**NAME OF PROVIDER OR SUPPLIER:**

ONEIDA COUNTY HOSPITAL & LONG TERM CARE

**STREET ADDRESS, CITY, STATE, ZIP CODE:**

150 NORTH 200 WEST.

MALAD, ID 83252

**[X4] ID PREFIX TAG**

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**PROVIDER'S PLAN OF CORRECTION**

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

**E 018**

Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths of the facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it.

- **Corrective action for identified areas/residents.**
  - On 3/15/2018 the facility's NHA, updated the ERP to include two new forms that are specific to staff and resident/patient tracking while sheltering in place.
  - Identification of residents with potential to be affected.
    - All residents and patients have the potential to be affected.
  - Measures to prevent occurrence.
    - A mandatory employee forum was scheduled for 3/27/2018. Facility staff will be educated regarding resident and staff resident/patient tracking during the employee forum.
  - **Monitoring and Quality Assurance**
    - The NHA, or designee, will conduct education regarding the facility's Emergency Response Plan (ERP) on 3/27/2018. This ERP education will include education regarding the facility's evacuation policies specific to staff and resident/patient tracking. Progress will be reported to the Quality Assurance Committee (QAC) monthly and as needed until a lesser frequency is deemed appropriate.
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Evacuation location(s) and primary and alternate means of communication with external sources of assistance.

*[For OPOs at § 486.360(b);] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.

* [*For ESRD at § 494.62(b);] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on record review, it was determined the facility failed to provide a policy for tracking of staff and sheltered residents during an emergency. Lack of a tracking policy for sheltered residents and staff has the potential to hinder the facility's ability to provide continuity of care during an emergency. This deficient practice affected 24 residents, staff and visitors on the date of the survey. Findings include:

Review of provided emergency plan, policies and procedures, conducted on 2/13/18 from 9:00 AM - 3:00 PM, failed to demonstrate the facility had in place a system to track the location of on-duty staff and sheltered residents during an emergency. Further review revealed the section under tab 3, labeled "Disaster Forms", revealed the form for staff was to be used in case of evacuation, but no forms or process was found for tracking residents and staff while sheltering.
E018 Continued From page 6
Reference:
42 CFR 483.73 (b)(2)

SS=D CFR(s): 483.73(b)(3)

[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (e) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:

Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.

* [For RNHCS at §403.748(b)(3) and ASCs at §416.64(b)(2);]
Safe evacuation from the [RNHC or ASC] which includes the following:
(i) Consideration of care needs of evacuees.
(ii) Staff responsibilities.
(iii) Transportation.
(iv) Identification of evacuation location(s).
(v) Primary and alternate means of communication with external sources of assistance.

* [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.82(b)(2);]
Safe evacuation from the [CORF; Clinics,
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**PROVIDER/SUPPLIER IDENTIFICATION NUMBER:** 135062

**MULTIPLE CONSTRUCTION**

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**DATE SURVEY COMPLETED:** 02/13/2018

**NAME OF PROVIDER OR SUPPLIER:** ONEIDA COUNTY HOSPITAL & LONG TERM C

**STREET ADDRESS, CITY, STATE, ZIP CODE:** 150 NORTH 200 WEST, MALAD, ID 83252

**SUMMARY STATEMENT OF DEFICIENCIES**

*(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)*

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Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities, which includes staff responsibilities, and needs of the patients.

* [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients.

This REQUIREMENT is not met as evidenced by:

Based on record review and interview, it was determined the facility failed to provide a policy and procedure specifying locations for evacuation during a disaster. Lack of a policy and procedure identifying the location for evacuations has the potential to create confusion and misinformation during an emergency, hindering continuity of care for the 24 residents, staff and visitors housed in the facility on the date of the survey.

Findings include:

On 2/13/18 from 9:30 AM - 2:00 PM, review of the provided emergency plan policies and procedures, found no policies or procedures specifying the location of the facility's evacuation point.

On 2/13/18 from 12:45 - 2:00 PM, interview of 3 of 3 staff revealed they were unaware of the specified evacuation point or of the facility's policy or procedure as to the facility or point of evacuation.

Reference:

42 CFR 483.73 (b) (3)

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

IDENTIFICATION NUMBER: 135062

(A)(2) MULTIPLE CONSTRUCTION
A. BUILDING: ________________
B. WING: ________________

DATE SURVEY COMPLETED: 02/13/2018

NAME OF PROVIDER OR SUPPLIER
ONEIDA COUNTY HOSPITAL & LONG TERM CARE
STREET ADDRESS, CITY, STATE, ZIP CODE
150 NORTH 200 WEST MALAD, ID 83252

ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

E 024 Continued From page 8

[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:]

(6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.

*[For RNHCs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by:

Based on record review and interview, it was determined that the facility failed to develop emergency policies, procedures and operational plans addressing the use of volunteers to during an emergency. Lack of a plan, policy and procedure specific to use of volunteers, has the potential to hinder the facility's ability to provide continuity of care during a disaster. This deficient practice affected 24 residents, staff and visitors on the date of the survey.

Findings include:

Review of provided emergency plan, policies and procedures

PREPARATION AND/OR EXECUTION OF THIS PLAN DOES NOT CONSTITUTE ADMISSION OR AGREEMENT BY THE PROVIDER OF THE TRUTHS OF THE FACTS ALLEGED OR THE CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE THE PROVISIONS OF FEDERAL AND STATE LAW REQUIRE IT.

E 024

Corrective action for identified areas/residents.

On 3/5/2018 a "State and Local Disaster Plan" tab was added to the ERP to identify the area of the ERP containing state and local emergency and volunteer organizations' contact information. The facility was in possession of an Emergency Operations Plan issued from the Idaho Bureau of Homeland Security as part of the Southern Idaho Regional Collaboration Project at the time of the survey. The facility was all in possession of the Oneida County Emergency Operations Plan at the time of the initial survey. These Emergency Operations Plans were not referenced in the facility's ERP. Information referencing these two Emergency Operations Plans was included under the newly added "State and Local Disaster Plan" tab.

Identification residents with potential to be affected.

All residents and patients have the potential to be affected.

Measures to prevent occurrence.

A mandatory employee forum was scheduled for 3/27/2018. Facility staff will be educated regarding where to find information in the facility's ERP related to State and Local Disaster Plans.

Monitoring and Quality Assurance

The NHA, or designee, will conduct education regarding the facility's Emergency Response Plan (ERP) on 3/27/2018. This
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**ID IDENTIFICATION NUMBER:** 135062

**MULTIPLE CONSTRUCTION**

**A. BUILDING**

**B. WING**

**DATE SURVEY COMPLETED:** 02/13/2018

**NAME OF PROVIDER OR SUPPLIER:** ONEIDA COUNTY HOSPITAL & LONG TERM CARE

**STREET ADDRESS, CITY, STATE, ZIP CODE:** 150 NORTH 200 WEST MALAD, ID 83252

**SUMMARY STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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procedures conducted on 2/13/18 from 9:00 AM - 3:00 PM, identified that Tab 4, labeled "Emergency Response Team & Equipment", page 3, section 15 had a section for "Volunteers" directed the facility to:

"Research local organizations and companies in the community that may volunteer to assist the center and obtain the contact person's name for each", and further stated to "Place the State and Local Disaster Plan under the tab 'State and Local Disaster plan tab', yet no section or identifying documentation related to these remarks was identified.

In addition, no documentation was found identifying a plan, policy or procedure as to how the facility would accept or utilize volunteer support of both professional and non-professional individuals with varying levels of skill and/or training.

Interview of 3 of 3 staff members on 2/13/18 from 12:45 - 2:30 PM, did not indicate any knowledge of the facility policy for the use of volunteers during an emergency.

Reference:
42 CFR 483.73 (b) (6)

**ID PREFIX TAG:** E 024

**SUMMARY STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ERP education will include education regarding the location of State and Local Disaster Plans and contact information.

Progress will be reported to the Quality Assurance Committee (QAC) monthly and as needed until a lesser frequency is deemed appropriate.

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**ID PREFIX TAG:** E 030

**SUMMARY STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

**Summary Statement of Deficiencies**

Names and Contact Information

CFR(s): 483.73(c)(1)

[(c) The [facility, except RNCHCs, hospices, transplant centers, and HHAs] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:]
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER:** ONEIDA COUNTY HOSPITAL & LONG TERM CARE  
**STREET ADDRESS, CITY, STATE, ZIP CODE:** 150 NORTH 200 WEST, MALAD, ID 83252

**IDENTIFICATION NUMBER:** 135062

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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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| E 030         | **Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths of the facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it.** | E 030         | **Corrective action for identified areas/residents.**  
Physician contact information is included on the facility's employee contact information pages under the "Emergency Response Team & Equipment" tab in the facility ERP. A separate sheet with just the provider's contact information was added under this tab on 3/6/2018. Also, provider contact information has been placed at the individual nurses' stations.  
**Identification residents with potential to be affected.**  
All residents and patients have the potential to be affected.  
**Measures to prevent occurrence.**  
A mandatory employee forum was scheduled for 3/27/2018. Facility staff will be educated regarding where to find provider contact information in the facility's ERP and on the unit.  
**Monitoring and Quality Assurance**  
The NHA, or designee, will conduct education regarding the facility's Emergency Response Plan (ERP) on 3/27/2018. This ERP education will include education regarding contact information for facility providers and where to find this information. Progress will be reported to the Quality Assurance Committee (QAC) monthly and as needed until a lesser frequency is deemed appropriate. | |
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135062

MULTIPLE CONSTRUCTION
A. BUILDING ___________
B. WING ___________

DATE SURVEY COMPLETED: 02/13/2018

NAME OF PROVIDER OR SUPPLIER: ONEIDA COUNTY HOSPITAL & LONG TERM C
STREET ADDRESS, CITY, STATE, ZIP CODE: 150 NORTH 200 WEST MALAD, ID 83252

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SUMMARY STATEMENT OF DEFICIENCIES
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(1) Names and contact information for the following:
   (i) Staff,
   (ii) Entities providing services under arrangement,
   (iii) Volunteers,
   (iv) Other OPOs,
   (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA).

This REQUIREMENT is not met as evidenced by:

Based on record review and interview, it was determined the facility failed to document a communication plan which included contact information for physicians. Failure to have contact information available for servicing physicians has the potential to hinder continuity of care during an emergency for the 24 residents housed in the facility on the date of the survey.

Findings include:

On 2/13/18 from 9:00 AM to 3:00 PM, review of provided emergency plan, policies and procedures, revealed the contact information provided did not have contact information for any resident physicians.

Reference:
42 CFR 483.73 (c) (1)