IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSSELL S. BARRON– Director

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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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September 22, 2017

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

Provider #: 135062

Dear Mr. Williams:

On **September 7, 2017**, we conducted an on-site revisit and a complaint investigation to verify that your facility had achieved and maintained compliance. We presumed, based on your allegation of compliance, that your facility was in substantial compliance as of **August 2, 2017.** However, based on our on-site revisit we found that your facility is not in substantial compliance with the following participation requirements:

- **225-Investigate/report Allegations/individuals-483.12(a)(3)(4)(c)(1)-(4)**

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.) **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 **October 2, 2017**.

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.

- 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*.

As noted in the Bureau of Facility Standards' letter of **July 3, 2017**, following the survey of **June 16, 2017**, we have already made the recommendation to the Centers for Medicare and Medicaid Services (CMS) for Denial of Payment for New Admissions and termination of the provider agreement on September 16, 2017, if substantial compliance is not achieved by that time. The findings of non-compliance on **September 7, 2017**, has resulted in a continuance of the remedy(ies) previously mentioned to you by the CMS.

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 the 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, 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.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You may also contest scope and severity assessments for deficiencies, which resulted in a finding of SQC or immediate jeopardy. 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:

- BFS Letters (06/30/11)

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

This request must be received by **October 2, 2017**. If your request for informal dispute resolution is received after **October 2, 2017**, 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,

Nina Sanderson, LSW, Supervisor
Long Term Care

NS/lj

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135062		R **09/07/2017**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS	{F 000}		
	The following deficiencies were cited during the revisit and complaint survey conducted at the facility from September 6, 2017 through September 7, 2017. The surveyors conducting the survey were: David Scott, RN, Team Coordinator Melanie Tatom, RN ABBREVIATIONS: CNA = Certified Nursing Assistant CNO = Chief Nursing Officer DNS = Director of Nursing Services MDS = Minimum Data Set			
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or	F 225		9/28/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/28/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	Continued From page 1 misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in	F 225		

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F 225	Continued From page 2 accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on resident, ombudsman and staff interview and record review, it was determined the facility failed to ensure all abuse allegations were thoroughly investigated, and failed to ensure residents were protected from potential further abuse while an allegation was investigated. This was true for 1 of 8 sampled residents (#4). The deficient practice created the potential for harm if residents experienced undetected and ongoing mistreatment. Findings include: The facility's "Abuse Investigating and Reporting" policy, dated 4/18/2017, documented: a. The investigator's role included interviewing staff members on all shifts who had contact with the resident during the period of the alleged incident. The investigator would obtain written witness reports. Either the witness wound write, sign, and date the statement, or the investigator would write the statement, read it back to the staff member and have him/her sign and date the statement. The policy documented the investigator would interview other residents to whom the accused employee provided care and services. b. The Administrator would immediately suspend any employee who had been accused of resident abuse pending the outcome of the investigation.	F 225	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truths of the facts alleged or 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 Actions Taken: The facility's policy relating to abuse investigations has been updated to include specific duties of the individual conducting the investigation including but not limited to: Interviewing the person reporting the incident; interviewing any witnesses to the incident including staff members, roommates, family members and visitors; interviewing the resident (as medically appropriate); interviewing the resident's attending physician as needed to determine the resident's current level of cognitive function and medical condition; interviewing staff members who have had contact with the resident during the timeframe of the alleged incident; and, interviewing residents to whom the accused employee provides care and services in a manner that protects the privacy and confidentiality of all involved. The facility's policy relating to abuse	

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F 225	Continued From page 3 Resident #4's Minimum Data Set (MDS) assessment, dated 8/29/17, documented the resident had moderately impaired cognition, could walk in her room with the assistance of two staff, had a history of non-injury falls, and used oxygen. The MDS documented the resident's diagnoses included non-Alzheimer's dementia, Parkinson's disease, depression, and bipolar disorder. Resident #4's 7/21/17 self-care deficit care plan documented the resident required two person assistance at all times due to "threats to call State of Idaho/Police with multiple complaints." Resident #4's Treatment Administration Record for August 2017 documented the resident received 2 liters of oxygen per nasal cannula with exertion or any physical activity, due to a diagnosis of chronic respiratory failure. On 8/31/17, a "Resident Abuse Investigation Report" (abuse report) for Resident #4 documented an allegation of abuse was made on 8/24/17. The report documented CNA #1 had been outside Resident #4's room, but observed the resident inside the room standing unassisted and reaching for some boxes, not wearing her oxygen. CNA #1 entered the room alone to assist the resident, due to the resident's fall risk, then assisted the resident to put her oxygen back on. The report documented Resident #4 accused CNA #1 of replacing the oxygen cannula in an abusive manner, which prompted CNA #1 to immediately leave the room and ask CNA #2 go to assist the resident. CNA #1 then self-reported the allegation to the Administrator.	F 225	investigations has been updated to indicate that employees who have been accused of resident abuse may be reassigned to nonresident care duties or the staff member may be suspended from duty until the results of the investigation have been reviewed by the Administrator. If the employee is reassigned to nonresident care duties, the employee will not have access to the resident until the investigation has been unsubstantiated and reviewed by the Administrator. Staff was educated regarding resident rights and the right to be from abuse on 9/21/17. Identification: All residents have the potential to be affected. Monitoring Performance: A sweep of all residents was conducted to identify if any residents have experienced abuse or mistreatment on 9/27/2017. No residents alleged abuse or mistreatment. The LCSW and Administrator will review all investigations prior to completion to assure a full investigation has been completed for at least three instances of reported abuse or for a period of time not less than three months if there are over three abuse allegations within the prior to the end of a three month period. Results of these reviews will be reported at the facility's monthly QAPI meeting. Progress and trending relating to this deficiency will be monitored by the QAPI team. If the QAPI team determines that further monitoring is necessary, reviews of abuse allegation investigations will continue per	

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F 225	Continued From page 4 The 8/31/17 abuse report documented statements from Resident #4, CNA #1, and CNA #2. The report documented Resident #4 was "incredibly irate" and denied being in a standing position when CNA #1 entered the room. The resident's statement documented CNA #1 had placed the nasal cannula back in the resident's nose in an abusive manner. The report documented the abuse allegation was unsubstantiated. The "Corrective Action Taken" section of the report documented CNA #1 was assigned to another hall. The 8/31/17 abuse report did not document statements from any other residents or staff. The report did not document that CNA #1 was suspended from duty while the investigation was ongoing. The facility's "Payroll Hours August 24" report documented 12 CNAs worked in the facility on 8/24/17. The Payroll Hours reports documented CNA #1 worked on 8/25/17 (1.5 hours) and 8/26/17 (7.25 hours). On 9/6/17 at 10:45 am, CNA #1 stated she saw Resident #4 in her room in an unsafe position on 8/24/17, and went into the room to intervene. CNA #1 stated after she got the resident situated on her bed and put her oxygen on, Resident #4 accused CNA #1 of "shoving" the cannula in her nose. CNA #1 stated she immediately left the room, got CNA #2 to go help Resident #4, and went to report the allegation to the Administrator. On 9/6/17 at 10:45 am, the Ombudsman stated she was aware of several incidents with Resident #4, and visited with her at least quarterly. The	F 225	the QAPI team's recommendations. Two set of the QAPI minutes will be retained by the Nursing Home Administrator (NHA) or designee. Responsible Party: NHA or designee. Completion Compliance will be established by 9/28/2017. Auditing will continue as indicated to assure compliance.	

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F 225	Continued From page 5 Ombudsman stated she had not visited with Resident #4 about this particular incident, but was aware CNA #1 had been reassigned after it occurred. The Ombudsman stated she would have expected CNA #1 to be suspended from duty while the investigation was underway. On 9/6/17 at 11:07 AM, CNA #2 stated CNA #1 had asked her to go into Resident #4's room on the day in question after Resident #4 had instructed CNA #1 not to "shove" the oxygen tubing up her nose. CNA #2 stated Resident #4 was able to put her own oxygen tubing on. On 9/6/17 at 1:30 pm, CNA #3 stated she had been working on the day Resident #4 made this particular allegation, although the resident had a tendency to often accuse staff of mistreatment. CNA #3 stated Resident #4 was agitated on the day in question, and told her CNA #1 had "tried to choke her" with the oxygen tubing. CNA #3 stated she had not been asked to give a statement as part of the investigation. On 9/6/17 at 2:50 pm, Resident #4 recalled the event in question, and identified CNA #1 by description. Resident #4 stated she cried and thought her nose was going to bleed after her oxygen was reapplied. Resident #4 stated she did not think CNA #1 meant to hurt her, but acted "mad" and left the room "abruptly." On 9/6/17 at 3:30 pm, the Administrator and Chief Nursing Officer (CNO) stated Resident #4's care plan called for 2 person assistance in part because of the frequency of her accusations against staff. The Administrator stated in this particular situation, CNA #1 correctly entered the	F 225		

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F 225	Continued From page 6 room without waiting for a second staff person due to the concern for Resident #4's safety, and again acted correctly when she self-reported the allegation immediately after it occurred. The Administrator stated he immediately began his investigation, and reassigned CNA #1 to care for other residents, but did not suspend the CNA. The Administrator stated Resident #4 was tearful when approached, and stated the CNA acted deliberately. The Administrator stated that though he felt he could rule out abuse based on the statements from CNA #1 and Resident #4, he left the investigation open for a time as Resident #4 had a history of changing her story. The Administrator stated he did not interview other residents as part of this allegation, although he had done so with other allegations this resident made. On 9/7/17 at 11:45 am, the Administrator stated he was aware some staff had used the word "choked" to describe the incident, but those were individuals who were not directly involved in the situation. The Administrator stated "uninvolved third parties" made for poor interviews during an investigation. The facility did not conduct a thorough interview of Resident #4's allegation when they did not conduct interviews with other residents receiving care from the accused CNA, or other staff members working when the event occurred. The facility allowed the accused CNA to continue to work with other residents while the investigation into the abuse allegation was conducted.	F 225		