IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RUSS BARRON – Director

TAMARA PRISOCK—ADMINISTRATOR
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BUREAU OF FACILITY STANDARDS
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Boise, Idaho 83720-0009
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March 16, 2018

Melissa Truesdell, Administrator
Owyhee Health & Rehabilitation Center
PO Box A
Homedale, ID 83628-2040

Provider #: 135087

Dear Ms . Truesdell:

On **March 9, 2018**, 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 **March 26, 2018**. Failure to submit an acceptable PoC by **March 26, 2018**, may result in the imposition of penalties by **April 20, 2018**.

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 <u>in column (X5)</u>.

  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 **April 13, 2018 (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 **June 7, 2018**. A change in the seriousness of the deficiencies on **April 23, 2018**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **June 7, 2018** includes the following:

Denial of payment for new admissions effective **June 7, 2018**. [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 **September 5, 2018**, 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 Debby Ransom, RN, RHIT, Bureau Chief, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 5; 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 **June 7, 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:

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 **March 26, 2018**. If your request for informal dispute resolution is received after **March 26, 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, comments or concerns, please contact Debby Ransom, RN, RHIT, Bureau Chief at (208) 334-6626, option 5.

Sincerely,

Debby Ransom, RN, RHIT, Chief
Bureau of Facility Standards

dr/lj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135087		**03/09/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWYHEE HEALTH & REHABILITATION CENTER	**108 WEST OWYHEE** **HOMEDALE, ID 83628**

(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 The following deficiencies were cited during the federal recertification and complaint investigation survey conducted March 5, 2018 to March 9, 2018. The surveyors conducting the survey were: Teresa Kobza, RDN, LD, Team Coordinator Cecilia Stockdill, RN ABBREVIATIONS: DNS = Director of Nursing CNA = Certified Nursing Assistant G-Tube = Gastrostomy Tube MDS = Minimum Data Set mg = milligrams LPN = Licensed Practical Nurse	F 000		
F 559 SS=D	Choose/Be Notified of Room/Roommate Change CFR(s): 483.10(e)(4)-(6) §483.10(e)(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement. §483.10(e)(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement. §483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by:	F 559		4/6/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/22/2018

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 559	Continued From page 1 Based on observation, interview, and record review, it was determined the facility failed to provide written notice before a resident room was changed and to notify another resident of a new resident moving into the room. This was true for 2 of 2 sample residents (# 8 and #12) reviewed for a room change, and created the potential for harm should the resident experience a diminished sense of self-worth due to lack of control over their environment. Findings include: 1. The facility's Room to Room Transfer Policy/Procedure, dated 11/2016, documented the following: * The resident would be provided with advance notice of a room transfer, and the notice would include the reason for the recommended move. * Prior to the room transfer, the resident, his/her roommate, and the resident's representative would be provided with information regarding the decision for the room transfer. * A roommate would be informed of any new transfer into their room, including the reason for the transfer and any additional information that would be helpful to the roommate transition. Resident #8 was admitted on 3/15/2009 with multiple diagnoses including cerebellar ataxia (loss of coordinated muscle movement) and essential hypertension (high blood pressure). Resident #8's quarterly MDS assessment, dated 2/2/18, documented moderate cognitive impairment.	F 559	CORRECTIVE ACTION: Owyhee Health & Rehabilitation has in-serviced the social service designee on new federal guidelines regarding notification requirements related to room changes. Verification of receipt of the written notification of room change will be maintained in the resident's medical record. IDENTIFICATION OF OTHER RESIDENTS AFFECTED: All current residents and new admissions have the potential to be affected. SYSTEMIC CHANGES/PREVENTION MEASURES: Social Services Designee will assist and document, notifications as well as acceptance, of all room changes prior to execution. Period documentation will address resident impact and concerns will be addressed at the time of identification. Facility policy/procedure will be updated to meet state and federal regulations MONITORING OF CORRECTIVE ACTION: A weekly audit will be completed the by Social Services Designee to monitor compliance. QAPI Committee will review all room changes no less than quarterly to ensure compliance with state and federal regulations until deficiency is no longer a concern to the IDT	

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F 559	Continued From page 2 A Notification of Room or Roommate Change, dated 3/7/18, documented Resident #8 was moved to a different room and the resident was informed in person on 3/7/18. On 3/5/18 at 2:21 PM Resident #8 resided in room #22. On 3/8/18 at 3:00 PM, Resident #8 was residing in room #23. Resident #8 said she did not remember any details about moving into a different room. Resident #12 occupied the other bed in room #23. On 03/8/18 at 3:04 PM, the DNS said she left a message for Resident #8's son the night before and left a message for her daughter earlier on the morning of 3/8/18 regarding moving the resident to a different room. The DNS said Social Services was not involved in the room change. The DNS said she filled out a room change form, which was an internal document used by the facility, and they did not provide a copy of the form or written notification to the resident or her family. On 03/8/18 at 3:10 PM, the Administrator said usually she and/or the DNS discuss room and roommate changes with the resident, and if the resident is agreeable to the move they will contact the resident's family. On 3/9/18 at 9:38 AM, Resident #8's family member said she received a message in the afternoon a day or two ago from the DNS regarding the resident moving into a new room. Resident #8's family member said she called back the next morning and was told they moved	F 559		

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F 559	Continued From page 3 Resident #8 into another room because the facility was doing renovations. Resident #8's family member said she did not receive any written notification of the room change. 2. Resident #12 was admitted on 2/27/17 with multiple diagnoses including Alzheimer's Disease and mood disorder. Resident #12's annual MDS assessment, dated 2/14/18, documented short term and long term memory problems. On 3/6/18 at 3:00 PM, Resident #12 was the sole occupant of her room (#23). On 3/8/18 at 3:00 PM, Resident #8 was residing in the same room as Resident #12. On 3/8/18 at 3:04 PM, the DNS said she talked to Resident #12 about getting a new roommate but did not talk to the resident's family. On 3/9/18 at 9:43 AM, Resident #12's family member said he received a call from the facility's Administrator the previous day around 1:00 PM that Resident #12 had a new roommate. Resident 12's family member said he talked to the resident last night she did not mention a roommate. Resident #12's family member stated they did not receive any written notification regarding a change in roommate status.	F 559		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan,	F 658		4/12/18

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F 658	Continued From page 4 must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of policies and procedures (P&P), it was determined the facility failed to ensure professional standards of quality were maintained for 1 of 1 residents (#190) sampled for tube feeding. Specifically, when Resident #190 was administered water via gastrostomy tube without proper positioning. This failed practice created the potential for harm if the resident aspirated and other complications arose related to the use of Resident #190's G-tube. Findings include: 1. Resident #190 was admitted on 2/23/18 with diagnoses including protein calorie malnutrition, dysphagia, and gastrostomy. On 3/05/18 at 3:54 PM, Registered Nurse (RN) #1 was observed administering 60 cc of water via Resident #190's G-tube. After the administration of the water RN #1 was ready to begin Resident #190's tube feeding administration. RN #1 was asked about the positioning of Resident #190 and she stated the resident's head of the bed was elevated. Resident #190's head of the bed was approximately at a 30-degree angle. Resident #190 had slid down in bed to where he was lying flat on his back, his feet were extended past the end of the bed, approximately 10 inches. On 3/5/18 at 3:54 PM RN #2 present during the observation assisted RN #1 with repositioning Resident #190 up in bed further.	F 658	CORRECTIVE ACTION: Owyhee Health & Rehabilitation will educate all licensed nursing on staff on safe technique for enteral tube feedings. Licensed staff will be re-educated at least annually and prn through various processes. Competencies will be conducted for all new hires and no less than annually and prn. IDENTIFICATION OF OTHER RESIDENTS AFFECTED: All current and new residents who receive enteral tube feedings have the potential to be affected. SYSTEMIC CHANGES/PREVENTION MEASURES: DNS/Designee will randomly observe scheduled tube feedings for appropriate positioning and administration of nutrition as well as pre/post medication administration flushes. MONITORING OF CORRECTIVE ACTION: An audit will be done once weekly by the Director of Nursing Services or designee. QAPI Committee will follow enteral tube feeding professional standards until they are no longer a concern to the IDT	

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F 658	Continued From page 5 On 3/6/18 at 10:17 AM the Regional RN Consultant stated when administering any kind of medications, fluids, or tube feedings residents should be minimally elevated to 30 - 45 degrees.	F 658		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure residents receiving psychoactive medication monitored the efficacy of the medication. This was true for 1 of 5 (#32) sampled residents who received psychoactive medications. This deficient practice created the potential for harm if	F 757	CORRECTIVE ACTION: Owyhee Health & Rehabilitation has educated Social Service Designee and all behavior tracking has been separated out to reflect the tracking required for the individual medication class. All behavior tracking has been reviewed to ensure tracking	3/22/18

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F 757	Continued From page 6 residents received medications that may result in negative outcomes without clear indication of need. Findings include: Resident #32 was admitted to the facility on 6/13/17 with diagnoses which included dementia with behavioral disturbances, single episode of major depression, and Alzheimer's disease. A quarterly MDS assessment, dated 2/16/18 documented Resident #32 had a moderate cognitive impairment and no signs or symptoms of depression. The Psychotropic Medication Use Care Plan, dated 8/29/17, documented Resident #32 required the medication related to her dementia with psychosis. The care plan documented Resident #32 was tearful, self-isolated, had delusional thoughts, and increased anger or agitation. The February 9, 2018 Medication Regimen Review (MMR) documented Resident #32's depression medication was due for consideration of a gradual dose reduction (GDR). On February 23, 2018 the physician responded to the pharmacist's recommendation to GDR the Celexa by responding, "pt (patient) has depression, hx (history) of psychosis, has severe delusions/hallucinations. Doing well, GDR contraindicated." The March 2018 Physician orders documented Resident #32 received 10 mg of Celexa for depression once daily, ordered 6/13/17, and Risperdal 0.5 one time a day and 1 mg at bedtime for Behavioral and Psychological	F 757	includes the appropriate targeted behavior. IDENTIFICATION OF OTHER RESIDENTS AFFECTED: All current residents and new admissions have the potential to be affected. SYSTEMIC CHANGES/PREVENTION MEASURES: All care plans are reviewed quarterly by the IDT to ensure all targeted behaviors are reflected for the medication class being administered. MONITORING OF CORRECTIVE ACTION: Behavior tracking will be audited monthly during the monthly Psychotropic Meeting by the Director of Nursing Services or designee to ennsure compliance. QAPI Committee will follow behavior tracking issues until they are no longer a concern to the IDT	

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F 757	Continued From page 7 Symptoms of Dementia, ordered 9/18/17. Resident #32's Medication Administration Record (MAR) from 2/1/18 through 3/7/18, documented staff routinely administered her Risperdal and Celexa. Resident #32's Behavior tracking was on the MAR 2/1/18 through 3/7/18 which documented staff monitored Resident #32 for tearfulness, self-isolation, delusional thinking, and increased anger or agitation. The behavior tracking did not include hallucinations. On 3/9/18 at 11:49 AM, the DNS and the LPN #1 stated when Resident #32 first came to the facility she saw hallucinations. and had delusions. The DNS stated Resident #32 would focus on seeing her son and anger would control her life. The DNS stated the facility was not currently monitoring for hallucinations. The DNS stated she would correct the issue.	F 757		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		3/22/18

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F 880	Continued From page 8 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed	F 880		

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OWYHEE HEALTH & REHABILITATION CENTER	108 WEST OWYHEE HOMEDALE, ID 83628

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F 880	Continued From page 9 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, it was determined the facility failed to ensure hand hygiene practices were performed in a manner consistent with current CDC guidelines. This was true for 2 of 20 sample residents (#7 and #20) and for one kitchen staff member. This failed practice created the potential for residents to develop infections from cross-contamination. Findings include: 1. The facility's Handwashing Policy/Procedure, dated 5/2007, documented the following: * "Hand washing is generally considered the most important single procedure for preventing nosocomial (facility acquired) infections." * Staff were directed to wet hands and apply soap to hands, rub hands in a circular motion for not less than 15 seconds, rinse hands with warm water, dry hands with a paper towel, and turn off the faucet using a paper towel.	F 880	CORRECTIVE ACTION: Owyhee Health & Rehabilitation has in-serviced all staff on hand washing per CDC guidelines. Facility policy/procedure updated to reflect hand washing guidelines per current CDC recommendations. All new hires are in-serviced on proper hand washing during the orientation period. Routine training and staff education is provided no less than annually and PRN to maintain compliance. IDENTIFICATION OF OTHER RESIDENTS AFFECTED: All current residents and new admissions have the potential to be affected. SYSTEMIC CHANGES/PREVENTION MEASURES: Policy/procedure updated. DNS/Designee will do random Hand washing observations throughout the building	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	135087		**03/09/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWYHEE HEALTH & REHABILITATION CENTER	**108 WEST OWYHEE** **HOMEDALE, ID 83628**

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F 880	Continued From page 10 * Waterless hand cleansing products may be used in areas where a sink is not readily available; however, hand washing with soap and water should be completed as soon as possible. The Center for Disease Control and Prevention (3/7/16) documented the following recommendations for appropriate hand hygiene: * Hands should be washed before, during, and after food preparation, before eating, and before and after using the toilet. * Wet hands with clean, running water and apply soap. * Scrub hands for at least 20 seconds. * Rinse hands well under clean, running water. * Dry hands using a clean towel. * When using hand sanitizer, apply the sanitizer to the palm of one hand, rub hands together and rub sanitizer over all surfaces of hands and fingers until dry. Resident #7 was admitted on 10/8/16 with multiple diagnoses including chronic kidney disease and frequency of urination. On 3/5/18 at 11:45 AM, CNA #2 assisted Resident # 7 to the toilet in the resident's room. When Resident #7 was done toileting, CNA #2 assisted the resident to stand and cleansed the resident's peri area. CNA #2 assisted Resident #7 off the toilet and into her wheelchair, and then	F 880	MONITORING OF CORRECTIVE ACTION: Audits will take place twice weekly by the Director of Nursing Services or Designee. The QAPI Committee will follow hand washing issues until they are no longer a concern to the IDT	

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F 880	Continued From page 11 CNA #2 removed her gloves . CNA #2 did not perform hand hygiene and wheeled the resident out of her room and down the hall towards the dining room. CNA #2 said she should have washed her hands after assisting Resident #7 to the toilet and she did not. CNA #2 said hand hygiene should be performed after providing care to a resident. CNA #2 said hands should be washed for 30 seconds, or use use hand sanitizer "until it's rubbed in." On 3/05/18 at 3:33 PM, CNA #1 was assisting Resident #20 to the restroom and after she assisted Resident #20 with her needs CNA #1 was observed washing her hands. CNA #1 turned the water on, put soap in her hand and rubbed her hands together for 3 seconds, and then rinsed her hands under running water. CNA #1 dried her hands with paper towels and turned the water off. CNA #1 assisted Resident #20 out of the restroom and repeating the process. On 3/09/18 at 9:16 AM, the Cook #1 was observed washing her hands. The Cook turned the water on, put soap in her hand and rubbed her hands together for 3 seconds, and then rinsed her hands under running water. Cook #1 dried her hands with paper towels and turned the water off. On 3/9/18 at 10:13 AM, the Infection Control Specialist LPN stated stated the observations described above were inappropriate forms of hand hygiene. The RN stated during cares staff should perform hand hygiene, prior to assisting residents, before transitioning from dirty to clean, and after cares were completed. The LPN stated gloves should be changed when transitioning from dirty to clean and hand hygiene as well	F 880		

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F 880	Continued From page 12 performed. The LPN stated staff should wash their hands for a minimum of 20 seconds with soap and water and if hand sanitizer was used then until their hands were dry. The LPN stated she did not teach hand hygiene in the kitchen.	F 880		

Bureau of Facility Standards

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	MDS001660		**03/09/2018**

NAME OF PROVIDER OR SUPPLIER
OWYHEE HEALTH & REHABILITATION CENTE

STREET ADDRESS, CITY, STATE, ZIP CODE
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C 000	INITIAL COMMENTS The following deficiencies were cited during the State licensure survey of your facility March 5, 2018 to March 9, 2018. The surveyors conducting the survey were: Teresa Kobza, RDN, LD, Team Coordinator Cecilia Stockdill, RN	C 000		
C 422	02.120,05,p,vii Capacity Requirments for Toilets/Bath Areas 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. This Rule is not met as evidenced by: 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: On 3/13/18 at 1:39 PM, the Administrator acknowledged the facility was licensed for 49 beds; however, the building's two tubs and one shower met the requirement for only 36 beds. On 3/13/18 at 1:39 PM, the Administrator requested to continue a waiver for the bathing facilities.	C 422	This facility requests the continuance of the waiver that has existed for many years in this facility. 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.	3/22/18

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/22/18

IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK—ADMINISTRATOR
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January 7, 2019

Melissa Truesdell, Administrator
Owyhee Health & Rehabilitation Center
PO Box A
Homedale, ID 83628-2040

Provider #: 135087

Dear Ms. Truesdell:

On **March 9, 2018**, an unannounced on-site complaint survey was conducted at Owyhee Health & Rehabilitation Center. The complaint was investigated in conjunction with the facility's on-site Recertification and State Licensure survey conducted March 5, 2018 through March 9, 2018.

The complaint allegations or entity-reported incidents, findings and conclusions are as follows:

Complaint #ID00007645

ALLEGATION #1:

The air fresheners may cause worsening respiratory reactions.

FINDINGS #1:

Several residents were observed throughout the survey for respiratory status or conditions. Staff were observed throughout the survey providing various respiratory care to residents.

The clinical records of several residents' were reviewed for quality of life and quality of care concerns. The facility's Grievance files, the facility's Incident and Accident reports, the facility's Alleged Abuse reports, and Resident Council minutes from November 2017 through March 2018 were reviewed for respiratory induced issues from the air fresheners and none were found.

Several residents and several staff members were interviewed regarding respiratory care and the air freshener in the building and stated their liking for the air fresheners.

The Director of Nursing, Administrator, and Corporate Regional Nurse were interviewed regarding the use of the air fresheners in the building.

The air fresheners were observed on the lowest settings throughout the survey.

Based on record review and staff interview, it was determined the allegation was unsubstantiated.

CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

If you have any questions, comments or concerns regarding this matter, please contact Laura Thompson, RN, or Belinda Day, RN, Supervisors, Long Term Care Program at (208) 334-6626, Option #2.

Sincerely,

Belinda Day

Belinda Day, RN, Supervisor
Long Term Care Program

BD/lj