



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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

November 20, 2018

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

Provider #: 135062

Dear Mr. Williams:

On **October 26, 2018**, a survey was conducted at Oneida County Hospital & Long Term Care Facility by the Idaho Department of Health and Welfare, Division of Licensing and Certification, Bureau of Facility Standards to determine if your facility was in compliance with state licensure and federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and/or Medicaid program participation requirements. **This survey found the most serious deficiency to be one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.**

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567 listing Medicare and/or Medicaid deficiencies. 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.

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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 **November 30, 2018**. Failure to submit an acceptable PoC by **November 30, 2018**, may result in the imposition of penalties by **December 23, 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 in column (X5).

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

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

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **December 7, 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 **January 26, 2019**. A change in the seriousness of the deficiencies on **December 10, 2018**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **January 26, 2019** includes the following:

Denial of payment for new admissions effective **January 26, 2019**. [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 **April 26, 2019**, 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 **January 26, 2019** 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>

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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 **November 30, 2018**. If your request for informal dispute resolution is received after **November 30, 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,

A handwritten signature in black ink that reads "Debby Ransom". The signature is written in a cursive style and is positioned above the typed name and title.

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

DR/lj

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

PRINTED: 05/03/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135062</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/26/2018</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ONEIDA COUNTY HOSPITAL &amp; LONG TERM CARE FACILITY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>150 NORTH 200 WEST MALAD, ID 83252</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the federal recertification and complaint survey conducted at the facility from October 22, 2018 to October 26, 2018.</p> <p>The surveyors conducting the survey were: Brad Perry, LSW, Team Coordinator Carmen Blake, RN</p> <p>Survey Abbreviations: CNA = Certified Nursing Assistant DON = Director of Nursing LPN = Licensed Practical Nurse MAR = Medication Administration Record MDS = Minimum Data Set assessment PA = Physician Assistant</p>	F 000		
F 583 SS=E	<p>Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii)</p> <p>§483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records.</p> <p>§483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>§483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened</p>	F 583		12/2/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <b>Electronically Signed</b>	TITLE	(X6) DATE <b>11/23/2018</b>
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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 583	<p>Continued From page 1</p> <p>mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.</p> <p>§483.10(h)(3) The resident has a right to secure and confidential personal and medical records.</p> <p>(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.</p> <p>(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure privacy during a medical examination for 3 of 12 residents (#7, #21, and #22) who were observed for privacy. This failure created the potential for residents to be embarrassed when a medical examination was provided in a common area. Findings include:</p> <p>The facility's dignity policy, dated 2/13/17, directed staff to protect resident privacy during treatment procedures.</p> <p>a. On 10/23/18 at 11:38 AM, a PA performed an examination of Resident #21's ears with an otoscope (a lighted instrument used to visualize the middle ear) while Resident #21 was seated in the day room with other residents and visitors present.</p>	F 583	<p>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.</p> <p>F583--PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>Corrective Actions Taken: The Director of Nursing Services (DNS) spoke to the Physician's Assistant (PA) that was providing on-site audiology services on 10/23/2018. She instructed him regarding facility expectations related to treating</p>		

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F 583	<p>Continued From page 2</p> <p>b. On 10/23/18 at 11:43 AM, the PA performed an examination of Resident #22's ears while seated in the day room with other residents and visitors present.</p> <p>c. On 10/23/18 at 11:20 AM, Resident #7 was awake and lying in a recliner in the activity day room. Directly across from Resident #7 was another resident and the Licensed Clinical Social Worker (LCSW). There was also 3 other residents present in the activity room. The PA and CNA #1 were next to Resident #7. The PA inspected her ears with an otoscope and cleaned wax out of her ears.</p> <p>On 10/23/18 at 11:25 AM, the DON said residents should not be examined in a public area.</p> <p>On 10/23/18 at 11:45 AM, the PA said it would have taken too long to take the residents into an exam room or into their own rooms.</p> <p>On 10/23/18 at 11:32 AM, the LCSW said he saw the PA examine Resident #7's ears but was engaged in conversation with the resident sitting next to him. The LCSW said the PA's examination was not appropriate.</p> <p>On 10/23/18 at 11:44 AM, CNA #1 said she was assisting the PA to identify where the residents were. CNA #1 said she did not attempt to move Resident #7 to a private room to be examined because it would have been too much work to move her out of the recliner.</p>	F 583	<p>residents in public areas. The PA expressed his apologies and indicated he would only provide the services in private areas moving forward. LCSW and CNA 1 were interviewed on 11/21/2018 by NHA. Both individuals indicated that they are aware that residents should be taken to a private room or area for personal cares, examinations and treatments.</p> <p>A root cause analysis completed on 11/21/2018 revealed that this service was recently added to the facility's list of on-site service providers. The PA providing the service is familiar with nursing home regulations and recognizes that patient services should be conducted in a private area. The PA was shown our facility "clinic" room that can be used for examinations and treatments and is specifically designed and equipped for this purpose. He indicated that he would use this room during future visits.</p> <p>Facility nursing staff will be educated regarding residents' personal privacy and confidentiality during care processes by 11/30/2018.</p> <p>Identification Process: All residents have the potential to be affected.</p> <p>Monitoring Performance and Effectiveness: Following a sweep of all public areas in the facility conducted on 11/23/2018 by the DNS, no other deficient practices were identified regarding the personal privacy and confidentiality of</p>		

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F 583	Continued From page 3	F 583	<p>residents during cares/examinations. To assure compliance, the DNS, or a designee, will conduct walking rounds of the facility to assure resident privacy and confidentiality during cares, examinations and treatments is being appropriately addressed by staff and visiting specialists.</p> <p>These walking rounds will be conducted five days a week for two weeks, then three days per week for two weeks, then weekly for one month. The walking rounds audits will be reviewed at the facility's monthly QAPI Committee meeting. Progress and trending related to this deficiency will be monitored by the QAPI Committee. If the QAPI Committee determines that further monitoring is necessary, audits will continue per the QAPI Committee's recommendations. Two sets of the QAPI Committee minutes related to this deficiency will be retained by the Nursing Home Administrator (NHA), or designee.</p> <p>Responsible Party: DNS or designee</p> <p>Completion Date: Compliance will be established by 12/2/2018. Auditing will continue as indicated to assure ongoing compliance.</p>		
F 690 SS=D	<p>Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)</p> <p>§483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to</p>	F 690		12/2/18	

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F 690	<p>Continued From page 4</p> <p>maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.</p> <p>§483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-</p> <p>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;</p> <p>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and</p> <p>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.</p> <p>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, and resident and staff interview, it was determined the facility failed to ensure an order was in place for an indwelling urinary catheter for 1 of 1 resident (Resident #1) reviewed for indwelling catheter use. The failure created the potential for harm if</p>	F 690	<p>F 690--BOWEL/BLADDER INCONTINENCE, CATHETER, UTI</p> <p>Corrective Actions Taken: A sweep of all facility residents with indwelling catheters was conducted on 10/24/2018 to assure</p>		

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F 690	<p>Continued From page 5</p> <p>the resident developed a urinary tract infection due to unnecessary catheter use. Findings include:</p> <p>The facility's Indwelling Catheter policy, dated 10/4/18, directed catheters should have a physician order which included a diagnosis and size of the catheter.</p> <p>Resident #1 was readmitted to the facility on 5/16/18, with multiple diagnoses including urinary retention and benign prostatic hyperplasia (enlargement of the prostate gland).</p> <p>Resident #1's hospital History and Physical, dated 5/9/18, documented he had an indwelling catheter.</p> <p>Resident #1's 5/16/18, readmission orders did not include an order for an indwelling catheter.</p> <p>Resident #1's October 2018 physician recapitulation orders and treatment administration record, directed staff to change the catheter as clinically indicated and to provide catheter care each shift by a licensed nurse. The orders did not include the diagnosis for the catheter, the size of the catheter or the size of the balloon.</p> <p>Resident #1's current care plan directed staff to provide catheter care each shift along with other essential infection control measures. The care plan did not include documentation of the size of the catheter or the balloon size.</p> <p>On 10/22/18 at 3:04 PM, Resident #1 said he was not sure why he had a catheter.</p>	F 690	<p>that physician orders for indwelling catheters included information specifying the size of the catheter and the size of the balloon. Resident #1, as identified during survey, was the only resident in the facility with an indwelling catheter.</p> <p>A review of facility policies related to urinary catheter care indicated that the policy specifically instructs staff to consult the physician order for proper catheter size and balloon size when changing and/or inserting a catheter.</p> <p>Facility nursing staff and physicians will be educated on the policy by 11/30/2018.</p> <p>Identification Process: All residents with orders for an indwelling catheter have the potential to be affected <input type="checkbox"/> one current resident identified.</p> <p>Monitoring Performance and Effectiveness: Following a sweep of all physician orders for residents with indwelling catheters conducted on 10/24/2018, the DNS identified no other deficiencies related to physician orders for residents with indwelling catheters.</p> <p>To assure compliance, the DNS, or a designee, will audit physician orders for residents with indwelling catheters reports for accuracy and completeness five days a week for two weeks, then three days per week for two weeks, then weekly for one month. These audits will be reviewed at the facility <input type="checkbox"/>'s monthly QAPI Committee</p>		

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F 690	Continued From page 6  On 10/24/18 at 11:31 AM, LPN #1 said if the catheter needed to be changed she would check the physician's order to verify the catheter and balloon size.  On 10/24/18 at 11:44 AM, the DON said Resident #1's clinical record should have had an order and a diagnosis for the catheter and should have included an order for the size of the catheter and the size of the balloon.	F 690	meeting. Progress and trending related to this deficiency will be monitored by the QAPI Committee. If the QAPI Committee determines that further monitoring is necessary, audits will continue per the QAPI Committee's recommendations. Two sets of the QAPI Committee minutes related to this deficiency will be retained by the Nursing Home Administrator (NHA), or designee.  Responsible Party: DNS or designee  Completion Date: Compliance will be established by 12/2/2018. Auditing will continue as indicated to assure ongoing compliance.		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4)  §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census.  §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data	F 732		12/2/18	

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F 732	<p>Continued From page 7</p> <p>specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.</p> <p>(ii) Data must be posted as follows:</p> <p>(A) Clear and readable format.</p> <p>(B) In a prominent place readily accessible to residents and visitors.</p> <p>§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, and staff interview, it was determined the facility failed to maintain the posted daily nurse staffing data for a minimum of 18 months. This was true for 25 of 25 residents living in the facility (#1-#25), their family members, and/or visitors who wanted to know facility staffing levels. Findings include:</p> <p>On 10/23/18 at 10:43 AM, the facility's daily nurse staffing hours were documented on a white dry erase board at the nurses' station. The dry erase board documented a census of 25 residents (#1-#25) with licensed staff for each shift on that day. The Ward Clerk said she had been updating the daily postings for several years and had not kept the information she posted.</p>	F 732	<p>F732--<input type="checkbox"/>POSTED NURSE STAFFING INFORMATION</p> <p>Corrective Actions Taken: During the survey process, the DNS produced a specific form that she is able to run that would meet the requirements related to posting nurse and CNA staffing information. This information was not readily available for the residents and their families, but the DNS is able to pull the information and post it moving forward. The nurse and CNA staffing information will then be stored in a binder on the unit and staffing records will be retained in this binder for a minimum of eighteen (18) months. Facility staff will be educated on the new process by</p>		

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NAME OF PROVIDER OR SUPPLIER  <b>ONEIDA COUNTY HOSPITAL &amp; LONG TERM CARE FACILITY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>150 NORTH 200 WEST MALAD, ID 83252</b>		
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F 732	Continued From page 8 On 10/23/18 at 11:53 AM, the DON said the facility should have kept staff posting information.	F 732	11/30/218.  Identification Process: All residents have the potential to be affected.  Monitoring Performance and Effectiveness: To assure compliance, the DNS, or a designee, will audit facility nurse staffing log reports for accuracy and completeness and will make sure these reports are accessible to residents and their families. These audits will be conducted five days a week for two weeks, then three days per week for two weeks, then weekly for one month.  These audits will be reviewed at the facility's monthly QAPI Committee meeting. Progress and trending related to this deficiency will be monitored by the QAPI Committee. If the QAPI Committee determines that further monitoring is necessary, audits will continue per the QAPI Committee's recommendations. Two sets of the QAPI Committee minutes related to this deficiency will be retained by the Nursing Home Administrator (NHA), or designee.  Responsible Party: DNS or designee  Completion Date: Compliance will be established by 12/2/2018. Auditing will continue as indicated to assure ongoing compliance.		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		12/2/18	

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

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F 880	<p>Continued From page 9</p> <p>§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.</p> <p>§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:</p> <p>§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;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a</p>	F 880			

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F 880	<p>Continued From page 10 resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(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</p> <p>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§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 observation and staff interview, it was determined the facility failed to ensure exam equipment was appropriately cleaned and disinfected between residents for 2 of 12 residents (#21 and #22) who were observed for infection control. This failure created the potential for harm by exposing residents to the risk of infection and cross-contamination. Findings include:</p>	F 880	<p>F880--<input type="checkbox"/>INFECTION PREVENTION &amp; CONTROL</p> <p>Corrective Actions Taken: The Director of Nursing Services (DNS) spoke to the Physician's Assistant (PA) that was providing on-site audiology services on 10/23/2018. She instructed him regarding facility expectations related to infection</p>		

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F 880	<p>Continued From page 11</p> <p>On 10/23/18 at 11:38 AM, a PA performed an examination of Resident #21's ears while he was seated in the day room. The PA examined his ears with an otoscope. Upon completion of the examination, the PA placed the instrument in his back pocket and completed a conversation with Resident #21.</p> <p>On 10/23/18 at 11:43 AM, the PA removed the otoscope from his back pocket and performed an ear examination of Resident #22's ears. This was the same otoscope used for the exam on Resident #21. The otoscope was not disinfected before use on Resident #22.</p> <p>On 10/23/18 at 11:45 AM, the PA said he did not disinfect the otoscope between the residents' examinations. The PA said he should have cleaned the otoscope before and after each resident's examination.</p>	F 880	<p>prevention &amp; control. The PA again expressed his apologies and indicated he was aware that he needed to disinfect his equipment between uses and knows the proper steps to disinfect the otoscope.</p> <p>A root cause analysis completed on 11/21/2018 revealed that this service was recently added to the facility's list of on-site service providers. The PA providing the service is familiar with nursing home regulations and recognizes that examination tools needed to be disinfected between uses. The analysis also indicated that the otoscope the PA was using has the ability to apply individual use covers that can be discarded after each use. The facility will purchase the same otoscope tool and the individual use covers so the PA will not have to use his equipment when he comes. If he chooses to use his own equipment, the facility will have individual use covers that he can use. The PA indicated he would follow this process moving forward.</p> <p>Facility central supply personnel will purchase the otoscope and individual use covers by 11/30/2018. Also, specialists providing auditory canal examinations and cleanings on-site will be educated regarding the location of the facility's otoscope and related equipment by 11/30/2018. Facility nursing staff will be educated regarding infection prevention and control during care processes and assessments by 11/30/2018.</p>		

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F 880	Continued From page 12	F 880	<p>Identification Process: All residents have the potential to be affected.</p> <p>Monitoring Performance and Effectiveness: Following a sweep of all public areas in the facility conducted on 11/23/2018 by the DNS, no other deficient practices were identified regarding infection prevention and control during cares/examinations. To assure compliance, the DNS, or a designee, will conduct walking rounds of the facility to assure infection prevention and control policies during cares are being followed by staff and visiting specialists.</p> <p>These walking rounds will be conducted five days a week for two weeks, then three days per week for two weeks, then weekly for one month. The walking rounds audits will be reviewed at the facility's monthly QAPI Committee meeting. Progress and trending related to this deficiency will be monitored by the QAPI Committee. If the QAPI Committee determines that further monitoring is necessary, audits will continue per the QAPI Committee's recommendations. Two sets of the QAPI Committee minutes related to this deficiency will be retained by the Nursing Home Administrator (NHA), or designee.</p> <p>Responsible Party: DNS or designee</p> <p>Completion Date: Compliance will be</p>		

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F 880	Continued From page 13	F 880	established by 12/2/2018. Auditing will continue as indicated to assure ongoing compliance.		



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

BRAD LITTLE – Governor  
DAVE JEPPESEN – Director

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

May 2, 2019

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

Provider #: 135062

Dear Mr. Williams:

On **October 22, 2018** through **October 26, 2018**, an unannounced on-site complaint survey was conducted at Oneida County Hospital & Long Term Care Facility. During the investigation, seven residents' records were reviewed and care and services provided to six residents were observed. Multiple interviews were completed with residents, family members, and staff. The complaint allegations, findings and conclusions are as follows:

**Complaint #ID00007582**

ALLEGATION #1:

Residents were not assisted into night clothes at bedtime and had to sleep in their day clothes.

FINDINGS #1:

Three residents were observed in bed with night clothes on.

Three of four residents' records did not document a concern with night clothes. A facility incident and abuse form, dated 7/16/17, documented a resident who was admitted on 1/22/09 was left in her day clothes all night. The investigation documented several staff members were interviewed and the allegation could not be substantiated.

John Williams, Administrator  
May 2, 2019  
Page 2 of 3

Three of four residents interviewed said staff assisted them into their pajamas at night. Several Certified Nursing Assistants and nurses said residents were assisted into their pajamas at night.

The allegation could not be substantiated due to lack of sufficient evidence.

#### CONCLUSIONS:

Unsubstantiated. Lack of sufficient evidence.

#### ALLEGATION #2:

Residents did not receive oxygen therapy during the night due to lack of staff assistance with nasal cannulas. In the morning, the cannulas are found on the floor and dirty.

#### FINDINGS #2:

Six residents were observed to have their oxygen nasal cannulas either in their nose or stored in a sanitary manner.

Seven of seven resident records were reviewed, including a resident who was admitted on 1/22/09, documented orders for oxygen and infection control measures were in place. An incident and abuse form, dated 7/16/17, documented a resident who was admitted on 1/22/09 had her oxygen cannula left on the floor by staff members. The investigation documented several staff members were interviewed and the allegation was found to be unsubstantiated.

Multiple residents were interviewed and said staff assisted them with placement of oxygen equipment and when not in use the equipment was stored in a sanitary manner. Several CNAs and nurses said residents' oxygen nasal cannulas were kept in a sanitary manner and if a nasal cannulas was found on the floor, it would be immediately replaced before the resident used it again.

The allegation could not be substantiated due to lack of evidence.

#### 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.

John Williams, Administrator  
May 2, 2019  
Page 3 of 3

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

Sincerely,



Sylvia Creswell, LSW, Supervisor  
Long Term Care Program

SC/lj