



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0009  
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February 24, 2020

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

Provider #: 135062

Dear Mr. Williams:

On **February 7, 2020**, 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.

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 5, 2020**. Failure to submit an acceptable PoC by **March 5, 2020**, may result in the imposition of penalties by **March 28, 2020**.

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 **March 13, 2020 (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 **May 7, 2020**. A change in the seriousness of the

deficiencies on **March 23, 2020**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by

**May 7, 2020** includes the following:

Denial of payment for new admissions effective **May 7, 2020**. [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 **August 7, 2020**, 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 Belinda Day, RN or Laura Thompson, RN, Supervisors Long Term Care, Bureau of Facility Standards, 3232 Elder Street, Post Office Box 83720, Boise, Idaho, 83720-0009; phone number: (208) 334-6626, option 2; fax number: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **May 7, 2020** 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

John Williams, Administrator  
February 24, 2020  
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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 5, 2020**. If your request for informal dispute resolution is received after **March 5, 2020**, 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 Belinda Day, RN, or Laura Thompson, RN, Supervisors, Long Term Care Program at (208)334-6626, option #2.

Sincerely,



Laura Thompson, RN, Supervisor  
Long Term Care Program

lt/dr

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

PRINTED: 03/06/2020  
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>02/07/2020</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	INITIAL COMMENTS  The following deficiencies were cited during the federal recertification survey conducted from February 3 through February 7, 2020.  The surveyors conducting the survey were:  Cecilia Stockdill, RN, Team Coordinator Sallie Schwartzkopf, LCSW  Survey Abbreviations:  2+ = two plus CNA = Certified Nursing Assistant DNS = Director of Nursing Services MAR = Medication Administration Record MDS = Minimum Data Set mg = milligrams	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25  § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the facility failed to ensure the resident's pulse was monitored appropriately for residents who received blood pressure medication. This was true for 1 of 5 residents (Resident #21) who were reviewed for	F 684	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	3/5/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <b>Electronically Signed</b>	TITLE	(X6) DATE <b>03/03/2020</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 684	<p>Continued From page 1</p> <p>unnecessary medications. This failure created the potential for harm if residents experienced adverse effects from blood pressure medication. Findings include:</p> <p>The facility's policy for Vital Signs, dated 11/5/19, documented the following:</p> <ul style="list-style-type: none"> <li>* "Licensed nurses are responsible for knowing the usual range of a resident's vital signs, analyzing and interpreting routine vital signs, and notifying the physician of abnormal findings."</li> <li>* An acceptable range for pulse was 60 to 100 beats per minute.</li> <li>* Vital signs were obtained by the nurse as indicated, when administering certain medications, or for monitoring the effectiveness of medications or therapies.</li> <li>* "Certain cardiac drugs are given only when a resident's pulse or blood pressure is within a certain range."</li> </ul> <p>Resident #21 was admitted to the facility on 2/6/19, with multiple diagnoses including heart failure, presence of a cardiac pacemaker, and hypertension (high blood pressure).</p> <p>Resident #21's physician orders included:</p> <ul style="list-style-type: none"> <li>* Apical pulse to be monitored every shift. The order started on 3/14/19.</li> </ul> <p>Resident #21's MARs for January and February 2020 documented metoprolol (blood pressure medication) was administered each day from January 1 through February 5, 2020.</p> <p>Resident #21's Weights and Vitals Summary documented his pulse was monitored as follows:</p>	F 684	<p>prepared and/or executed solely because the provisions of federal and state law require it.</p> <p><b>F684 □ QUALITY OF CARE</b></p> <p>Corrective Actions Taken: A sweep of all resident orders was conducted on 2/25/2020 to do determine if any other residents who are receiving blood pressure medications are subject to medication guidelines for apical pulse monitoring. Seven residents identified with who meet this criterium. All but one had appropriate documentation of apical pulse prior to medication administration.</p> <p>On 2/26/2020, facility nursing staff was educated regarding the need for conducting and recording apical pulse checks prior to the administration of blood pressure medication, specifically beta blockers. Nursing staff signed the education documentation and expressed understanding of this process.</p> <p>Identification Process: All residents receiving blood pressure medications, specifically beta blockers, are affected.</p> <p>Monitoring Performance and Effectiveness: During the sweep of resident charts, seven residents were found to have orders for blood pressure medications with guidelines related to apical pulse monitoring. An audit was created for these residents to assure that apical pulse is being conducted and</p>		

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F 684	Continued From page 2  * 1/6/20 at 10:29 AM = 70 * 1/7/20 at 4:55 AM = 66 * 1/13/20 at 7:05 PM = 70 * 1/19/20 at 11:32 PM = 47 * 1/20/20 at 9:36 AM = 65 * 1/27/20 at 3:54 PM = 70 * 2/5/20 at 12:38 AM = 69  Resident #21's Weights and Vitals Summary did not document his pulse was monitored each shift as ordered by the physician.  On 2/6/20 at 10:06 AM, the DNS said did not find documentation Resident #21's pulse was checked every shift.	F 684	recorded in accordance with medication guidelines. The Director of Nursing Services (DNS), or a designee, will review the audits to assure compliance. This person will also review new admissions to determine the need to add them to this audit.  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. The walking rounds audits will be reviewed at the facility <input type="checkbox"/> s monthly Long-term Care Quality Assurance (LTC QA) Committee meeting. Progress and trending related to this deficiency will be monitored by the LTC QA Committee. If the LTC QA Committee determines that further monitoring is necessary, audits will continue per the LTC QA Committee <input type="checkbox"/> s recommendations. Two sets of the LTC QA 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 3/5/2020. Auditing will continue as indicated to assure ongoing compliance.		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)  §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		3/5/20	

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F 689	Continued From page 3  §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on policy review, record review, and staff interview, it was determined the facility failed to ensure residents were provided with the level of supervision necessary to prevent falls. This was true for 1 of 2 residents (Resident #14) reviewed for falls. This failure placed Resident #14 at risk of pain, bone fractures, brain damage, and other life changing injuries, as a result of falls. Findings include:  The CMS State Operations Manual, Appendix PP, the Long Term Care Facility federal regulations and guidance to surveyors, describes a fall as "unintentionally coming to rest on the ground, or other lower level, but not as a result of an overwhelming external force (e.g. resident pushes another resident). An episode where a resident lost his/her balance and would have fallen, if not for another person, or if he or she had not caught him/herself, is considered a fall."  The facility's policy for Fall Risk Assessment, dated 1/7/20, documented the following:  * The facility provided an environment free from accident hazards "over which the facility has control," and the facility provided supervision and assistive devices to each resident as needed to prevent avoidable accidents. * Nursing staff and the medical provider reviewed a resident's record for previous falls, especially falls that occurred in the past 90 days, and	F 689	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.  F689☐FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  Corrective Actions Taken: A sweep of all resident care plans was conducted on 2/25/2020 to determine if any other residents who are at risk for falls have appropriate care planning and documentation related to personal monitoring. Care plans and documentation of monitoring was reviewed for all residents identified as being at risk for falls. The intent was to discover if appropriate care planning and observation/monitoring was being conducted following a fall event for each resident. Inconsistencies in immediate changes to care plans following an event were identified.  Subsequently, a Root Cause Analysis (RCA) was initiated to identify what part of		

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F 689	<p>Continued From page 4 recurrent falls over time.</p> <ul style="list-style-type: none"> <li>* Staff attempted to determine if the falls were related to recent changes in condition or new/changed medications.</li> <li>* The provider and nursing staff evaluated the resident for conditions that may predispose them to falls and identified underlying medical conditions that may increase the risk of injury from falling.</li> <li>* Facility staff identified environmental factors that may contribute to falling.</li> <li>* Facility staff and the medical provider collaborated to identify and address fall risk factors that could be changed.</li> <li>* The facility monitored the effectiveness of the care plan interventions, and modified the interventions as needed "in accordance with current standards of practice."</li> </ul> <p>The facility's policy for Falls and Fall Risk, dated 5/11/16, documented the following:</p> <ul style="list-style-type: none"> <li>* "Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes and try to prevent the resident from falling and try to minimize complications from falling."</li> <li>* Staff, with contribution of the physician, identified appropriate interventions to reduce the risk of falls.</li> <li>* If falls continued despite the primary interventions, staff implemented additional or different interventions, or indicated why the current intervention was appropriate.</li> <li>* If underlying causes of the falls could not be identified or resolved, staff tried various interventions until falling was reduced or stopped, or the cause of continued falling was identified as</li> </ul>	F 689	<p>the falls risk assessment and falls care planning could be changed to improve the fall risk monitoring quality outcomes. The RCA indicated that although care plan documentation stated that increased monitoring of residents following a fall was initiated, documentation of increased supervision related to falls was not found. The RCA clearly identified a need for the implementation of a Fall Risk Monitoring Form that can be used when increased monitoring is indicated as an intervention. This form should identify resident behaviors that could lead to a fall, the presence of staff in the resident's immediate area, and the actions of staff taken in the event of immediate staff intervention.</p> <p>The RCA also demonstrated some inconsistencies in staff charting related to their awareness of Resident 14's balance issues, the need for extensive staff assist during ambulation and assessing resident behaviors associated with pre-fall cues. Staff was educated regarding location of care plans, assisting residents at risk of falls upon ambulation, and identifying resident behavior that might preclude a resident's desire to ambulate or signify a resident's loss of balance. Staff was also educated regarding the use of the newly created Fall Risk Monitoring Form. Also, the DNS educated the Interdisciplinary Team regarding the fact that interventions should be reviewed and updated following each fall incident. This education was</p>		

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F 689	<p>Continued From page 5</p> <p>unavoidable.</p> <p>* Staff, in collaboration with the physician, identified and implemented relevant fall interventions to minimize serious consequences of falling.</p> <p>Resident #14 was admitted to the facility on 12/30/13, with diagnoses of Down Syndrome and Alzheimer's disease. On 12/4/19 he was admitted to a hospital for pneumonia and was readmitted to the facility on 12/8/19. On 12/17/19 he was admitted to a hospital for pneumonia and sepsis (the body's overwhelming and life-threatening response to infection that can lead to tissue damage, organ failure, and death) and was readmitted to the facility on 12/27/19.</p> <p>Resident #14's quarterly MDS assessments, dated 3/26/19 and 6/25/19, documented he was unable to complete the interview to assess his cognitive status. The MDS assessment documented he required extensive 1 person assistance for ambulating in his room and the corridor, and was totally dependent on the assistance of 1 person for locomotion in other locations in the facility. The MDS assessments also documented he required extensive assistance of 2+ persons for transfers. The assessments documented he was not steady, however, could stabilize himself without human assistance. Both assessments documented Resident #14 used a wheelchair and had experienced 2 or more falls since the last MDS assessment. Both assessments documented Resident #14 experienced shortness of breath or trouble breathing upon exertion, such as while walking and during transfers.</p>	F 689	<p>completed on 2/27/2020.</p> <p>Identification Process: All residents have the potential to be affected.</p> <p>Monitoring Performance and Effectiveness: To assure compliance, the NHA, or a designee, will conduct a review of all resident fall incidents to assure that care plans are updated. Fall incidents will be reviewed at least weekly. Also, the DNS, or a designee will review the Fall Risk Monitoring Form 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 LTC QA Committee meeting. Progress and trending related to this deficiency will be monitored by the LTC QA Committee. If the LTC QA Committee determines that further monitoring is necessary, audits will continue per the LTC QA Committee's recommendations. Two sets of the LTC QA Committee minutes related to this deficiency will be retained by the Nursing Home Administrator (NHA), or designee).</p> <p>Responsible Party: Title or designee</p> <p>Completion Date: Compliance will be established by 3/5/2020. Auditing will continue as indicated to assure ongoing compliance.</p>		

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F 689	<p>Continued From page 6</p> <p>Resident #14's annual MDS assessment, dated 9/24/19, documented the same information noted above on the prior two MDS assessments, with the following exceptions. The 9/24/19 MDS assessment documented Resident #14:</p> <p>*Required extensive assistance from 1 person for transfers. The prior two assessments documented he required extensive assistance of 2+ staff for transfers.</p> <p>*Required extensive assistance of 2+ persons for ambulating in his room or in the corridor. The prior two assessments documented he required extensive assistance of 1 person for ambulating in his room and the corridor.</p> <p>*Was not steady and was only able to stabilize with human assistance during transitions and walking. The two prior assessments documented he was unsteady, however, could stabilize without human assistance.</p> <p>The 9/24/19 MDS assessment also documented Resident #14 had 2 or more falls since the prior MDS assessment.</p> <p>Resident #14's MDS assessment, dated 1/7/20, completed following his discharge from the hospital on 12/27/19, documented Resident #14 required extensive assistance of 2+ persons for transfers. The 9/24/19 MDS assessment documented he required extensive assistance from 1 person for transfers. The 1/7/20 MDS assessment documented Resident #14 required extensive assistance of 2+ persons for ambulating in his room or in the corridor, and was totally dependent on physical assistance from 1 staff for locomotion in other areas of the facility. The MDS assessment documented Resident #14</p>	F 689			

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F 689	<p>Continued From page 7</p> <p>was not steady but was able to stabilize with human assistance during moving from a seated to a standing position, during walking, and during surface to surface transfers. The MDS assessment documented Resident #14 experienced shortness of breath or trouble breathing upon exertion, such as while walking and during transfers. The MDS assessment documented Resident #14 used a wheelchair and had 1 fall resulting in injury since readmission to the facility on 12/27/19.</p> <p>Resident #14's Morse Fall Scale assessments, used to determine a person's risk for falls, dated 5/22/19, 6/20/19, 7/5/19, 7/8/19, 8/13/19, 9/19/19, 10/29/19, 12/8/19, 12/27/19, 1/4/20, and 1/7/20, documented he was at high risk for falls.</p> <p>Resident #14's care plan documented he fell often. The care plan was initiated on 3/28/18. Interventions included the following:</p> <ul style="list-style-type: none"> <li>*Follow the facility's fall protocol. The intervention was initiated on 3/28/18.</li> <li>* Educate Resident #14/family/caregivers about safety reminders and action to take if a fall occurs. The intervention was initiated on 3/28/18.</li> <li>* Ensure Resident #14 is wearing non-skid socks when he is ambulating. This intervention was initiated on 3/28/18.</li> <li>* "Encourage safe choices. Cue and redirect with 1:1 as needed ..." The intervention was initiated on 3/30/18.</li> <li>* Encourage Resident #14 to sit in a recliner, not a rocking chair or swivel chair, in the day room. The intervention was initiated on 9/17/18.</li> <li>* He may choose to sit on the floor. "Offer alternatives and encourage safe choices. Assist</li> </ul>	F 689			

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F 689	Continued From page 8 him to the floor for safety, if he chooses. (He has a history of sitting down unexpectedly from prior to admit. Move at [Resident #14's] pace. [Wheelchair] for increased mobility when elder chooses not to ambulate. Observe for unsafe behavior and intervene before a fall occurs." The intervention was initiated on 8/31/18 and revised on 9/20/19. * "Low risk interventions" included: Orient to surroundings, use a colored call light, keep call light, water, and personal items within reach, remind him to ask for assistance, answer the call light promptly, keep the room uncluttered, maintain the bed at an appropriate height and the brakes locked, maintain adequate lighting, encourage him to wear shoes/slippers with non-skid soles or gripper socks, keep assistive devices in reach, educate resident/representative, monitor for changes in condition, complete the fall risk assessment every quarter, annually, with significant changes, and with falls. The intervention was initiated on 10/24/19. * "Moderate risk interventions" included: Close supervision and frequent monitoring, obtain orthostatic blood pressures at least quarterly (blood pressure when laying down, sitting, and standing), request a medication review with falls, educate resident to change position slowly, obtain an order for physical/occupation therapy, consult with vision and hearing specialists as needed, assess for need of bedside commode/urinal. The intervention was initiated on 10/24/19. * "High risk interventions" included: Place a fall risk indicator on the resident's name plate, increase frequent monitoring, assess for need of increased supervision (room close to the nurses'	F 689			

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F 689	<p>Continued From page 9 station), and offer toileting at least every 2 hours and as needed. The intervention was initiated on 10/24/19.</p> <p>* Wheelchair for increased mobility as needed to prevent falls. The intervention was initiated on 11/14/19.</p> <p>* When in the activity room [day room], assist with transferring from the wheelchair to recliner with the Prevalon-Seated Positioning System (a device used to reduce friction and shearing during transfers). The intervention was initiated on 1/8/20.</p> <p>Resident #14's Incident and Accident Reports documented he fell 6 times from 5/22/19 to 1/7/20 as follows:</p> <p>* On 5/22/19 at 11:15 AM, Resident #14 was in the day room, he stood up from the recliner, attempted to sit down in another chair, missed the chair, and fell on his bottom. Resident #14 complained of pain in his right hip. A witness statement documented Resident #14 stood up, ambulated, misjudged where the other chair was, and fell. An x-ray was obtained of the right hip, and there was no evidence of a fracture. The intervention included removing the other chair from the day room. * On 6/8/19 at 4:00 PM, a CNA was with Resident #14 when he attempted to sit in the recliner, misjudged the distance to the recliner and sat on the floor. The investigation report documented Resident #14 had gripper socks on at the time of the fall. The intervention documented on the investigation report included ordering two-sided gripper socks to prevent slipping. The report did not describe how the two sided gripper socks related to the documented reason for the fall. The need for Resident #14 to</p>	F 689			

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F 689	<p>Continued From page 10</p> <p>wear non-skid socks when ambulating was previously added to his care plan on 3/28/18.</p> <p>* On 7/5/19 at 2:25 PM, Resident #14 attempted to sit on the lap of another resident who was seated in a recliner in the day room, he missed the area and sat on the floor. A CNA witness statement included in the investigation report documented the CNA was playing a game with other residents and watching Resident #14 at the same time. The CNA documented Resident #14 was standing up walking prior to attempting to sit in the recliner occupied by another resident. The other resident moved her knee and he fell slowly to the floor. The CNA helped lower him to the floor. There were no documented interventions to prevent future falls. The investigation report did not address the need for Resident #14 to have extensive assistance from 1 person while ambulating, which did not occur prior to the fall.</p> <p>* On 7/8/19 at 3:25 PM, Resident #14 was walking in the day room and sat on the floor. There were no new interventions as he "frequently chooses to sit on the floor." A witness statement documented Resident #14 stood up from the chair, took 3 or 4 steps, and sat down on the floor. The investigation report did not address the need for Resident #14 to have extensive assistance from 1 person while ambulating, which did not occur prior to the fall.</p> <p>* On 8/13/19 at 12:45 PM, Resident #14 was assisted to a chair by a CNA, and he slid off the chair onto the floor with assistance from the CNA. There were no documented interventions put in place. A witness statement documented Resident #14 was being assisted from the</p>	F 689			

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F 689	<p>Continued From page 11</p> <p>wheelchair to the chair in the day room, the chair slid and the CNAs lifted him to the floor.</p> <p>* On 10/29/19 at 9:25 AM, Resident #14 was ambulating with assistance in the day room, and he sat on the floor with assistance from staff. The investigation documented Resident #14 was placed in a chair after breakfast, and he stood up and started walking. The intervention was using a mechanical lift to transfer Resident #14 to the chair. The witness statements were contradictory. One witness statement documented Resident #14 started to stumble, and a staff member helped lower him to the floor. Another witness statement documented Resident #14 was ambulating and tried to sit, so the staff member assisted him to the floor. Another witness statement documented Resident #14 got out of his chair, walked away, and started to stumble. Another staff member lowered him to the floor.</p> <p>* On 1/7/20 at 11:55 AM, Resident #14 stood up from his wheelchair in the day room, fell forward, and struck the floor. He was "under watch of staff at [the] time of fall," and was lying face down on the floor when he was found. Injuries included an open wound on his forehead near the left eye, measuring approximately 1.2 centimeters, and redness on the bridge of his nose, forehead, and around his left eye. Interventions included "closer monitoring by staff" and "limited education to elder on asking for help." A witness statement documented Resident #14 tried to stand up from his wheelchair, and he lost his balance and fell. Interventions included closer supervision by the aide in the day room. A hospital diagnostic report, dated 1/7/20, documented a CT scan (a type of</p>	F 689			

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F 689	<p>Continued From page 12</p> <p>x-ray image) was performed after Resident #14 fell, and there was no acute fracture of the cervical spine (neck area) or head. The hospital diagnostic report also documented Resident #14 did not have an intercranial hemorrhage (bleeding inside the skull). He did sustain bruising and swelling to the area of his left eye and a soft tissue injury to his left forehead.</p> <p>On 2/3/20 at 5:10 PM, Resident #14 was sitting in a recliner in the day room. Staff were intermittently coming in and out of the day room to interact with other residents, and an activity staff member was present and intermittently interacting with residents. There was not a staff member within reach of Resident #14, and it was not apparent Resident #14 was being monitored by a particular staff member.</p> <p>On 2/4/20 at 3:52 PM, the DNS said Resident #14 fell on 1/7/20 when he stood up and lost his balance. The DNS said Resident #14 was not independent with transfers or ambulation at that time, he had been ill and had declined, necessitating use of a wheelchair. The DNS said a staff member was in the room when Resident #14 fell, he was by the couch and she was across the room when he "stood up and fell just as fast as he stood up." The DNS said Resident #14 was not being monitored at any particular time intervals during that time. The DNS said she did not document "closer monitoring by staff," and what was meant was to find things to keep him occupied in the day room. The DNS said Resident #14 also had falls between 5/22/19 and 10/29/19 where he would sit on the floor, and he previously did that at home. The DNS said Resident #14 would miss the chair and sit on the</p>	F 689			

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F 689	<p>Continued From page 13</p> <p>floor, and it was not really a fall, but the facility completed all the paperwork. The DNS said "increased supervision" meant knowing where Resident #14 was. The DNS said Resident #14 was previously more ambulatory, and his room was not close to the nurse's station anymore.</p> <p>On 2/7/20 at 10:22 AM, the DNS said that to prevent falls, staff tried to help Resident #14 sit down. The DNS said Resident #14 would not remember if staff reminded him to ask for assistance. When reviewing the Fall Prevention Care Plans dated 5/22/19, 6/8/19, 7/5/19, 7/8/19, 10/29/19, and 1/7/20, which were attached to each Incident and Accident Report, the DNS said "Monitor in day room" meant staff was always there from 8:00 AM to 8:00 PM, and she did not know if it was documented how staff monitored Resident #14. The DNS said not all of the interventions marked on Resident #14's Fall Prevention Care Plans were reasonable for him, and there was not a specified time interval for "frequent monitoring."</p> <p>Each of Resident #14's six falls occurred in the facility's day room between 9:25 AM and 4:00 PM and all were witnessed by staff. Staff were not within proximity and/or sufficient in numbers to prevent the falls. Resident #14's ability to ambulate declined. The 9/24/19 and 1/7/20 MDS assessments documented he required extensive assistance of 2+ persons for ambulating in his room or in the corridor. The 3/26/19 and 6/25/19 MDS assessments document he required extensive assistance of 1 staff for the same activity. The 9/24/19 and 1/7/20 MDS assessments documented Resident #14 was not steady and was only able to stabilize with human</p>	F 689			

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F 689	Continued From page 14 assistance during transitions and walking. The 3/26/19 and 6/25/19 MDS assessments documented he was unsteady but was able to stabilize without staff assistance. Resident #14 was hospitalized twice in December 2019 for pneumonia. The facility failed to ensure Resident #14 received the level of supervision necessary to protect him from falls.	F 689			
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)  §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic  Based on a comprehensive assessment of a resident, the facility must ensure that---  §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;  §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;  §483.45(e)(3) Residents do not receive	F 758	3/5/20		

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F 758	<p>Continued From page 15</p> <p>psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and</p> <p>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.</p> <p>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, policy review, and staff interview, it was determined the facility failed to ensure appropriate behavior and side effect monitoring was documented for residents receiving psychotropic medications. This was true for 2 of 5 residents (#5 and #21) reviewed for unnecessary medications and created the potential for harm if residents experienced adverse side effects or behaviors from unnecessary psychotropic medications. Findings include:</p> <p>The facility's policy for Psychotropic Medications, dated 11/5/19, documented the following:</p> <p>* "Residents are not given psychotropic drugs unless the medication is necessary to treat a</p>	F 758	<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>F758 <input type="checkbox"/> FREE FROM UNNECESSARY PSYCHOTROPIC MEDS/PRN USE</p> <p>Corrective Actions Taken: A sweep of all resident orders was conducted on 2/25/2020 to do determine if any other residents who are receiving psychotropic</p>		

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F 758	<p>Continued From page 16</p> <p>specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s)."</p> <p>* The effects of the psychotropic medications, including the resident's physical, mental, and psychosocial well-being were evaluated on an ongoing basis, including "in accordance with nurse assessments and medication monitoring parameters consistent with clinical standards of practice, manufacturer's specifications, and the resident's comprehensive plan of care."</p> <p>* The resident's response to the medication, including progress towards goals and any adverse effects, were documented the resident's record.</p> <p>This policy was not followed.</p> <p>1. Resident #5 was admitted to the facility on 7/8/19 and readmitted to the facility on 9/9/19, with multiple diagnoses including major depressive disorder.</p> <p>Resident #5's physician orders documented the following:</p> <p>* Remeron (antidepressant medication) 30 mg at bedtime related to major depressive disorder. The order started on 7/29/19.</p> <p>* Trazodone (antidepressant medication) 50 mg at bedtime, related to major depressive disorder. The order started on 9/10/19.</p> <p>* Zoloft (antidepressant medication) 50 mg once per day, related to major depressive disorder. The order started on 2/1/20.</p> <p>Resident #5's MARs for January and February</p>	F 758	<p>medications are appropriately having all related behaviors tracked. There is a total of twenty residents currently in the facility who are taking a psychotropic (i.e., anti-depressant, anti-psychotic, anti-anxiolytic). All but two had appropriate documentation of behavior monitoring related to the medication for the last three months.</p> <p>A Root Cause Analysis (RCA) was initiated to identify why this process was missed for the two residents identified. The RCA demonstrated two things. First, Resident 21 was admitted with an order for an anti-anxiolytic related to his tracheostomy and associated occasional air hunger. This was not initially seen as a traditional behavior, and he was not set-up for behavior monitoring upon admission for air hunger anxiety. Second, Resident 5 had the appropriate behavior monitoring tracking in prior months, but this tracking was not carried over following the beginning of the new year 2020. An interview with the nurse that put the changeover information into the system indicates that when she put the changeover information into the system, she errantly put a January 2019 date in instead of a January 2020. This resulted in the system simply not printing a behavior tracking form for residents that weren't here in January of 2019. Resident 5 and Resident 21 had not admitted to the facility prior to January 1, 2020. The RCA did however affirm that daily documentation from nursing staff</p>		

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F 758	<p>Continued From page 17</p> <p>2020 documented the Remeron, Trazodone, and Zoloft were administered as ordered.</p> <p>Resident #5's care plan documented he had situational depression, initiated on 8/5/19. Staff were directed to administer medications as ordered and monitor/document for side effects and effectiveness. The care plan directed staff to monitor efficacy and adverse side effects of the medication during medication administration and pharmacy/behavior meeting, monitor behavior every shift, and monitor for symptoms addressed in the Black Box Warning information. The care plan directed staff to monitor/record the incidence of target behavior symptoms and document per the facility's protocol.</p> <p>There was no documentation found in Resident #5's record regarding monitoring for side effects of Remeron, Trazodone, or Zoloft.</p> <p>On 2/7/20 at 10:15 AM, the DNS said there should be documentation of side effect monitoring for Resident #5's Remeron, Trazodone, and Zoloft, and she could not find any documentation that it was done.</p> <p>2. Resident #21 was admitted to the facility on 2/6/19, with multiple diagnoses including major depressive disorder and anxiety disorder.</p> <p>Resident #21's physician orders documented lorazepam (antianxiety medication) 0.5 mg twice per day related to anxiety disorder. The order started on 5/7/19.</p> <p>Resident #21's MARS for January and February 2020 documented the lorazepam was</p>	F 758	<p>should have identified the absence of the behavior tracking report.</p> <p>Facility staff was educated regarding monitoring behaviors for all residents receiving anti-psychotic, anti-anxiolytic and anti-depressant medications on 2/26/2020. Specific education was provided related to staff identifying that behavior tracking processes are in place for each of these types of medications for each resident. Staff was also educated to the fact that side effect and behavior tracking will now be attached to the medication administration documentation process in Point Click Care.</p> <p>Identification Process: All residents who are receiving psychotropic medications.</p> <p>Monitoring Performance and Effectiveness: Moving forward, we will place the side effect tracking tool directly into the Point Click Care system so the nurse will be required to answer Yes or No as to whether there were any noted side effects when the nurse is documenting having given the medication. This will remove the physical task of having to print the side effect tracking tool and it will automatically roll from year to year. Also, Air Hunger Anxiety was added as a behavior to the behavior tracking tool for Resident 21 and will be monitored as such moving forward. An audit was created for all residents receiving psychotropic medications to assure that behavior tracking and side</p>		

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F 758	<p>Continued From page 18 administered as ordered.</p> <p>Resident #21's care plan documented the following:</p> <ul style="list-style-type: none"> <li>* Staff were directed to administer psychotropic medications as ordered by the physician and monitor for side effects and efficacy. Staff were directed to monitor for symptoms addressed in the Black Box Warning information. The intervention was initiated on 2/9/19 and revised on 2/22/19.</li> <li>* The care plan directed staff to monitor efficacy and adverse side effects of medications through medication administration and pharmacy/behavior meetings, and to monitor behaviors every shift. The intervention was initiated on 2/9/19.</li> </ul> <p>There was no documentation in Resident #21's record of behavior monitoring related to anxiety .</p> <p>On 2/7/20 at 10:14 AM, the DNS said there should be documentation of behavior monitoring for Resident #21's lorazepam. The DNS said she talked to the Licensed Clinical Social Worker, and the facility did not have documentation of behavior monitoring for Resident #21's lorazepam</p>	F 758	<p>effect tracking is being conducted and recorded. The Licensed Clinical Social Worker (LCSW), or designee, will review the audits to assure compliance. This person will also review new admissions to determine the need to add them to this audit.</p> <p>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. The walking rounds audits will be reviewed at the facility <input type="checkbox"/> monthly LTC QA Committee meeting. Progress and trending related to this deficiency will be monitored by the LTC QA Committee. If the LTC QA Committee determines that further monitoring is necessary, audits will continue per the LTC QA Committee <input type="checkbox"/> recommendations. Two sets of the LTC QA Committee minutes related to this deficiency will be retained by the NHA, or designee.</p> <p>Responsible Party: Licensed Clinical Social Worker (LCSW) or designee</p> <p>Completion Date: Compliance will be established by 3/5/2020. Auditing will continue as indicated to assure ongoing compliance.</p>		
F 880 SS=E	<p>Infection Prevention &amp; Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)</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</p>	F 880		3/5/20	

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F 880	<p>Continued From page 19</p> <p>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> <ul style="list-style-type: none"> <li>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</li> <li>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</li> <li>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</li> <li>(iv) When and how isolation should be used for a resident; including but not limited to: <ul style="list-style-type: none"> <li>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</li> </ul> </li> </ul>	F 880			

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F 880	<p>Continued From page 20</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 contract review, policy review, observation, and staff interview, it was determined the facility failed to ensure infection control surveillance was maintained for the contracted laundry services which processed residents' personal laundry. This deficient practice had the potential to impact 18 of 21 residents who had personal laundry services provided by the facility. This deficient practice placed residents at risk of infection from cross contamination. Findings include:</p> <p>The facility's contract with the off-site personal</p>	F 880	<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>F880 <input type="checkbox"/> INFECTION PREVENTION &amp; CONTROL</p>		

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F 880	<p>Continued From page 21</p> <p>laundry vendor, dated 5/1/13, documented the service provided laundry pick-up, wash, dry, fold, steam press and delivery of laundry items. The laundry was hygienically cleaned and handled to prevent recontamination for dust and dirt during transport. Provided with the personal laundry vendor's contract was a copy of the vendor's equipment information, dated 2016, which documented a Whirlpool Front-Loading Automatic Washer, Use and Care Guide, noted to be designed to use only HE High Efficiency detergents.</p> <p>The facility's Handling of Soiled Linen policy, dated 10/4/18, did not include a policy or procedure for personal laundry services.</p> <p>A Laundry policy, dated May 2019, was attached to the facility's contract with the off-site personal laundry vendor and documented the following:</p> <ul style="list-style-type: none"> <li>* The facility laundered linens and clothing in accordance with current CDC (Center for Disease Control) guidelines to prevent transmission of pathogens.</li> <li>* Soiled laundry was handled as little as possible, with minimum agitation to avoid contamination of air, surfaces, and persons.</li> <li>* Sorting of laundry occurred after washing.</li> <li>* Laundry was processed with the following hot or low-temperature processes: Hot-water cycle: Washed with detergent in a water temperature of 160 degrees or above for at least 25 minutes. Low-temperature cycle: Washed with chemicals suitable for a low-temperature washing (less than 160 degrees) at the proper concentration.</li> <li>* If laundry was sent off to be cleaned, the facility maintained an agreement with the laundry</li> </ul>	F 880	<p>Corrective Actions Taken: NHA and Infection Control Specialist/Chief Nursing Officer (CNO) toured offsite laundry facility and reviewed survey outcomes and CDC Guidelines for Environmental Infection Control in Healthcare Facilities with the current vendor for resident personal laundry services. We also reviewed the APIC Text of Infection Control and Epidemiology (Chapter 111 Laundry, Patient Linens, Textiles, and Uniforms). Using these references, we drafted a set of policies related to the vendor's personal laundry service compliant with CDC/APIC recommendations and requirements.</p> <p>It should be noted that the laundry service vendor identified in the 2567 only launders resident personal clothing. They do not launder facility linens and medical laundry. However, in taking immediate corrective action regarding our personal laundry vendor, we focused on the four main areas of concern identified summarized on page 24 of the 2567 as cited for the state survey dated 2/7/2020. They are: 1) transporting dirty and clean clothing in the trunk of a vehicle, 2) sorting of dirty clothing on the floor of the laundry area, 3) ensuring proper water temperatures, and 4) changing into clean clothing after handling dirty clothes and before processing clean clothes. Education was conducted with the current personal laundry vendor on 3/3/2020 related to these matters and the need to create parameters regarding appropriate</p>		

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F 880	<p>Continued From page 22</p> <p>service that stipulated the laundry was hygienically clean and handled to prevent recontamination for dust and dirt during transport. * Laundry staff were in-serviced on handling linens and laundry on a regular basis.</p> <p>On 2/6/20 at 11:22 AM, the Administrator said the facility's linen and personal laundry were sent out for laundering. He said the linen went to a professional linen service and the personal laundry went to a local residence for processing. He said the personal laundry vendor performed laundry at her home in her shop, and it was not likely she would be able to provide a policy for Infection Control or personal laundry, but he would attempt to obtain the information. Some time later, the Administrator provided the Laundry policy, as described above.</p> <p>On 2/6/20 at 1:54 PM, the MDS Coordinator said 3 residents in the facility opted to have their laundry done privately, and all the other residents had their personal laundry needs met by the facility. The MDS Coordinator said the CNAs placed the residents' dirty clothes in a blue bag in the dirty laundry closet, the clothes were rinsed out in the hopper if needed, and then the blue bag was placed at the back door for the laundry vendor to pick up every Thursday.</p> <p>On 2/6/20 at 1:58 PM, the Housekeeping Manager said the bags of clean personal laundry arrived at the back door, then they were taken to the housekeeping room, placed on hanger carts, covered with a sheet, and distributed. The Housekeeping Manager said the laundry vendor had a copy of the facility's Infection Control laundry policy and procedures, but he had never</p>	F 880	<p>handling of dirty and clean clothing, cross contamination and appropriate water temperatures when providing this service.</p> <p>Identification Process: All residents have the potential to be affected.</p> <p>Monitoring Performance and Effectiveness: First, dirty and clean clothing will no longer be transported in the same vehicle. Moving forward the laundry vendor will transport dirty clothing to her home in her pick-up truck and will bring the articles back to the facility in her car. If the vendor is unable to access either of these vehicles in the process, she will find a substitute vehicle to assure that she is not transporting dirty and clean laundry in the same vehicle.</p> <p>Second, dirty laundry will be sorted on a non-permeable covering that can be laundered after the final load of dirty clothing is laundered. This covering will also be cleaned with one-to-ten bleach solution after use for sterilization.</p> <p>Third, an inline thermometer was added to the hot water line coming from the vendor's hot water heater to the high efficiency washing machine. Water temperatures ranging up to over 160 degrees Fahrenheit were observed. The vendor will keep a daily log of water temperatures to show compliance with proper water temperatures for individual wash cycles. These water temperature logs will be made available to the NHA</p>		

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F 880	<p>Continued From page 23</p> <p>seen the laundry vendor's facility so he did not know if she followed it. The dirty clothing closet was observed as well as the hopper and blue bags for dirty laundry. The Housekeeping Manager said the laundry vendor came to the facility to pick up the blue bags, and if there were too many to fit in the closet they were placed on the ground at the back door.</p> <p>On 2/6/20 at 3:49 PM, the Administrator said he had not toured the off-site laundry facilities, and the facility trusted the vendor as they had been outstanding in the area for as long as the facility had been in business. The Administrator said he had not confirmed that the laundry vendor fulfilled the contract she signed.</p> <p>On 2/7/20 at 8:50 AM, the laundry vendor said she processed the facility's laundry in her own washing machine and dryer. She said she picked up the dirty laundry by the facility's back door at 9:00 A.M. every morning, and the dirty laundry was in clear plastic bags and blue bags with the tops closed. The laundry vendor said she transported the laundry in the trunk of her car and in the back seat of her car if needed. She placed a mat beneath the dirty clothes in the trunk and removed the mat for clean clothes. She used Clorox wipes on her car seats after transporting dirty clothes. The laundry vendor said the laundry room was 16 by 20 feet, and it was in the basement of her home with an entry directly from the outside. The laundry vendor said the washer and dryer were next to each other on pedestals, and they were on the opposite side of the room from the clean laundry and folding table. She said she sorted the facility's clothes on the floor in front of the washing machine before</p>	F 880	<p>upon request.</p> <p>Fourth, the vendor will wear a full-body apron or covering when loading, sorting and washing dirty laundry. This apron/covering will be removed prior to handling clean laundry.</p> <p>To assure compliance, the NHA, or a designee, will conduct onsite visits of the vendors laundry service area. These onsite visits will be conducted weekly for one month, then once per month of two months. Findings from these onsite visits will be reviewed at the facility's monthly LTC QA Committee meeting. Progress and trending related to this deficiency will be monitored by the LTC QA Committee. If the LTC QA Committee determines that further monitoring is necessary, audits will continue per the LTC QA Committee's recommendations. Two sets of the LTC QA Committee minutes related to this deficiency will be retained by the Nursing Home Administrator (NHA), or designee).</p> <p>Responsible Party: NHA or designee</p> <p>Completion Date: Compliance will be established by 3/5/2020. Auditing will continue as indicated to assure ongoing compliance.</p>		

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F 880	<p>Continued From page 24</p> <p>she placed them into the machine, and she mopped the laundry room floor twice a week. She said she washed urine soaked items on the 80 minute hot temperature cycle, and items such as blouses on the 47 minute warm cycle. She said she had no way to measure the water temperatures. She said she only took in laundry from the mentioned facility, and she washed her own laundry only if no or very little laundry from the facility was in the room. She said she kept her personal laundry separate from the facility's, but she used the same machine to process all the laundry. The laundry vendor said she sanitized the washing machine between her personal laundry and the facility's laundry through a complete cycle using a sanitizer made by the machine's manufacturer. She said if she found fecal matter in the facility laundry, she placed the laundry in a red bag, immediately returned it to the facility, and placed it in the dirty laundry room where the CNAs rinsed it. The laundry vendor said she wore scrubs while she sorted and washed the dirty clothes, and she wore the same scrubs when she transferred the clean clothes to the dryer and while folding them. The laundry vendor said she kept the facility's laundry separated with each resident's clothes in their own labeled laundry basket, and she delivered the laundry to the facility on Tuesdays and Fridays by transporting it in the trunk of her car.</p> <p>The facility's laundry vendor failed to ensure residents' personal laundry was not cross contaminated when she transported dirty and clean clothes in the trunk of her car, sorted dirty clothing on the floor, did not ensure proper washing temperatures, and did not change into</p>	F 880			

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F 880	Continued From page 25 clean scrubs after handling dirty clothes and before processing clean clothes.	F 880			

Bureau of Facility Standards

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C 000	INITIAL COMMENTS  The following deficiency was cited during the state licensure survey conducted at the facility from February 3 through February 7, 2020.  The surveyors conducting the survey were:  Cecilia Stockdill, RN, Team Coordinator Sallie Schwartzkopf, LCSW	C 000		
C 664	02.150,02,a Required Members of Committee  a. Include the facility medical director, administrator, pharmacist, dietary services supervisor, director of nursing services, housekeeping services representative, and maintenance services representative. This Rule is not met as evidenced by: Based on staff interview and review of the Infection Control meeting attendance records, it was determined the facility failed to ensure the Maintenance Supervisor attended the Infection Control meetings on a regular basis. This had the potential to affect all residents, staff, and visitors in the facility. Findings include:  On 2/6/20 at 2:55 PM, the Chief Operating Officer provided the Infection Control meeting attendance lists dated 1/29/19, 4/30/19, 7/30/19, and 11/5/19. The attendance list for did not document the Maintenance Supervisor attended the Infection Control Meeting on 1/29/19. The Chief Operating Officer said that the Maintenance Supervisor had not signed the attendance list.	C 664	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. C664□02.150, 02, A REQUIRED MEMBERS OF COMMITTEE  Corrective Actions Taken: A review of all Quality Assurance & Performance Improvement (QAPI) meetings was conducted. The review showed that during the year only two department heads missed the quarterly meeting: once by the Maintenance Supervisor and once by the Housekeeping Supervisor. The	3/5/20

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE  03/03/20
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Bureau of Facility Standards

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C 664	Continued From page 1	C 664	<p>NHA counseled both individuals regarding mandatory attendance of this meeting. A schedule of anticipated dates of this meeting was posted for the year so all department heads could plan around the meeting. Moving forward, if a critical situation arises that will keep a relevant member of the team from attending this meeting, they will be expected to send a replacement from their team and/or meet with the NHA both before and after the meeting. By doing this they can assure that quality initiatives from their department are appropriately presented at the meeting and that they are made aware of the quality initiatives occurring in other departments. After reviewing the minutes, the department head will sign the attendance roster as having presented and reviewed the material in absentia.</p> <p>Identification Process: All residents have the potential to be affected.</p> <p>Monitoring Performance and Effectiveness: To assure compliance, the NHA, or a designee, will review all QAPI attendance rosters for completeness following the QAPI meeting. This review will be conducted monthly for three months and then quarterly thereafter. Progress and trending related to this deficiency will be monitored by the LTC QA Committee. If the LTC QA Committee determines that further monitoring is necessary, audits will continue per the LTC QA Committee's recommendations. Two sets of the QM Committee minutes related to this deficiency will be retained</p>	
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001570</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/07/2020</b>
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NAME OF PROVIDER OR SUPPLIER  <b>ONEIDA COUNTY HOSPITAL &amp; LONG TERM C,</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) COMPLETE DATE
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C 664	Continued From page 2	C 664	<p>by the Nursing Home Administrator (NHA), or designee).</p> <p>Responsible Party: NHA or designee</p> <p>Completion Date: Compliance will be established by 3/5/2020. Auditing will continue as indicated to assure ongoing compliance.</p>	
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