



IDAHO DEPARTMENT OF
HEALTH & WELFARE

.BRAD LITTLE – Governor
DAVE JEPPESEN – Director

TAMARA PRISOCK – ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

May 10, 2019

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

Provider #: 135062

**RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER
LETTER**

Dear Mr. Williams:

On **May 2, 2019**, a Facility Fire Safety and Construction survey was conducted at **Oneida County Hospital & Long Term Care Facility** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when

John Williams, Administrator
May 10, 2019
Page 2 of 4

you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **May 23, 2019**. Failure to submit an acceptable PoC by **May 23, 2019**, may result in the imposition of civil monetary penalties by **June 14, 2019**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567. If a State Form was issued as well, it should also be signed, dated and returned.

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

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **June 6, 2019**, (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 **July 31, 2019**. A change in the seriousness of the deficiencies on **June 16, 2019**, may result in a change in the remedy.

John Williams, Administrator
May 10, 2019
Page 3 of 4

The remedy, which will be recommended if substantial compliance has not been achieved by **June 6, 2019**, includes the following:

Denial of payment for new admissions effective **August 2, 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 noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **November 2, 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, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **May 2, 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:

John Williams, Administrator
May 10, 2019
Page 4 of 4

<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:

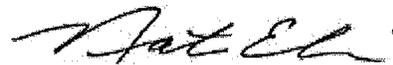
BFS Letters (06/30/11)

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

This request must be received by **May 23, 2019**. If your request for informal dispute resolution is received after **May 23, 2019**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626, option 3.

Sincerely,



Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures

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

PRINTED: 05/09/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135062	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 05/02/2019
NAME OF PROVIDER OR SUPPLIER ONEIDA COUNTY HOSPITAL & LONG TERM CARE FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 150 NORTH 200 WEST MALAD, ID 83252	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS The facility is a single story, Type III (211) building with a partial basement completed in November 1970. An addition was completed in 1993 with an attached Critical Access Hospital. The facility currently has a two-hour rated fire barrier which divides the structure, but does not create a separation between the CAH and the LTC sections of the building. The building is fully sprinklered and is protected by a complete fire alarm system with smoke detection in corridors and open spaces. The Essential Electrical System is supplied by a propane powered, on-site automatic generator. The facility is currently licensed for 33 SNF/NF beds and had a census of 23 on the date of the survey. The following deficiency was cited during the annual fire/life safety survey conducted on May 2, 2019. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70. The Survey was conducted by: Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction	K 000	RECEIVED MAY 28 2019 FACILITY STANDARDS	
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design,	K 353		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Jean WMS

CEO/OWIA

5/23/19

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135062	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 05/02/2019
NAME OF PROVIDER OR SUPPLIER ONEIDA COUNTY HOSPITAL & LONG TERM CARE FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 150 NORTH 200 WEST MALAD, ID 83252	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
K 353	<p>Continued From page 1</p> <p>maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure fire suppression system pendants were maintained free of obstructions such as paint or corrosion. Failure to maintain fire sprinkler pendants free of obstructions could hinder system performance during a fire event. This deficient practice affected staff and visitors on the date of the survey.</p> <p>Findings include:</p> <p>Observation during the facility tour on May 2, 2019, from approximately 2:00 PM to 4:30 PM, revealed two (2) sprinkler heads in the basement Central Supply Room, and four (4) sprinkler heads in the Central Supply Office, had non-factory paint on them. When asked, the Maintenance Director stated the facility was not aware the sprinkler had been painted.</p> <p>Actual NFPA standard: NFPA 25 5.2.1 Sprinklers.</p>	K 353	<p><i>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths of the facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it.</i></p> <p><u>K353</u></p> <ul style="list-style-type: none"> • Corrective action for identified areas/residents. The facility Maintenance Supervisor conducted a sweep of all facility fire suppression sprinkler heads on May 3rd, 2019 and identified all sprinklers that had paint or other debris on the casing. Those sprinklers that could be effectively cleaned were thoroughly cleaned. Viking Fire Protection was notified and came to the facility on May 19th, 2019. During their on-site visit, Viking Fire Protection replaced all sprinkler heads that were identified to have paint on them including the four sprinkler heads identified in during survey on May 2nd, 2019. • Identification residents with potential to be affected. All residents and patients have the potential to be affected. • Measures to prevent occurrence. All affected sprinkler heads have been identified and addressed. Moving forward, when any facility repairs or painting occurs, the Maintenance Supervisor, or his designee, will review the fire suppression sprinkler heads in the repaired/repainted area to make sure that paint has not been dripped or applied to the sprinkler head. Additionally, a sweep of the fire suppression sprinklers for paint and debris will be conducted as part of the annual review. • Monitoring and Quality Assurance The Maintenance Supervisor, or designee, will conduct a monthly audit

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

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NAME OF PROVIDER OR SUPPLIER ONEIDA COUNTY HOSPITAL & LONG TERM CARE FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 150 NORTH 200 WEST MALAD, ID 83252		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	Continued From page 2 5.2.1.1* Sprinklers shall be inspected from the floor level annually. 5.2.1.1.1* Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall). 5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical damage (4) Loss of fluid in the glass bulb heat responsive element (5)*Loading (6) Painting unless painted by the sprinkler manufacturer	K 353	demonstrating that the fire suppression sprinklers have been checked after repairs/repainting. This audit will be reported to the NHA weekly for three months. Progress will be reported to the Quality Assurance Committee (QAC) monthly and as needed until a lesser frequency is deemed appropriate. • Completion Date June 3rd, 2019.	



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3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

May 10, 2019

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

Provider #: 135062

RE: **EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER**

Dear Mr. Williams:

On **May 2, 2019**, an Emergency Preparedness survey was conducted at **Oneida County Hospital & Long Term Care Facility** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **May 23, 2019**. Failure to submit an acceptable PoC by **May 23, 2019**, may result in the imposition of civil monetary penalties by **June 14, 2019**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567. If a State Form was issued as well, it should also be signed, dated and returned.

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

Remedies may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **June 6, 2019**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on . A change in the seriousness of the deficiencies on **June 24, 2019**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **June 6, 2019**, includes the following:

Denial of payment for new admissions effective **August 2, 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 noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **November 2, 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, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **May 2, 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>

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

John Williams, Administrator

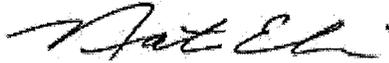
May 10, 2019

Page 4 of 4

This request must be received by **May 23, 2019**. If your request for informal dispute resolution is received after **May 23, 2019**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626, option 3.

Sincerely,

A handwritten signature in black ink, appearing to read "Nate Elkins".

Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj

Enclosures

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

PRINTED: 05/09/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135062	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/02/2019
NAME OF PROVIDER OR SUPPLIER ONEIDA COUNTY HOSPITAL & LONG TERM CARE FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 150 NORTH 200 WEST MALAD, ID 83252	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments The facility is a single story, Type III (211) building with a partial basement completed in November 1970. An addition was completed in 1993 with an attached Critical Access Hospital. The facility currently has a two-hour rated fire barrier which divides the structure but does not create a separation between the CAH and the LTC sections of the building. The building is fully sprinklered and is protected by a complete fire alarm system with smoke detection in corridors and open spaces. The Essential Electrical System is supplied by a propane powered, on-site automatic generator. The facility is currently licensed for 33 SNF/NF beds and had a census of 23 on the date of the survey. The following deficiency was cited during the emergency preparedness survey conducted on May 2, 2019. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73. The Survey was conducted by: Linda Chaney Health Facility Surveyor Facility Fire Safety and Construction	E 000	RECEIVED MAY 28 2019 FACILITY STANDARDS	
E 006 SS=F	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk	E 006		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Handwritten Signature]

TITLE

[Handwritten Title]

(X6) DATE

[Handwritten Date]

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135062	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/02/2019
NAME OF PROVIDER OR SUPPLIER ONEIDA COUNTY HOSPITAL & LONG TERM CARE FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 150 NORTH 200 WEST MALAD, ID 83252	
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E 006	<p>Continued From page 1 assessment, utilizing an all-hazards approach.*</p> <p>*[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.</p> <p>*[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.</p> <p>(2) Include strategies for addressing emergency events identified by the risk assessment.</p> <p>* [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to include strategies to address all emergency events identified by the facility-based and community-based risk assessment. Failure to develop strategies for response to all hazards identified by the facility risk assessment hinders the facility's ability to respond to localized disasters and emergencies. This deficient practice affected 23 residents, staff and visitors on the date of the survey.</p> <p>Findings include: On May 2, 2019, from approximately 10:45 AM to 2:00 PM, review of the provided emergency</p>	E 006	<p><i>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths of the facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it.</i></p> <p>E006</p> <ul style="list-style-type: none"> Corrective action for identified areas/residents. On May 3rd, 2019 the facility Nursing Home Administrator (NHA) and facility Maintenance Supervisor reviewed the most recent Hazard Vulnerability Analysis (HVA) as contained in the facility's Emergency Response Plan (ERP). The HVA was compared to the strategies for addressing emergency events. Certain emergencies listed on the HVA did not have strategies addressing the emergencies. Also, certain emergencies listed on the HVA did not apply to the facility. During the review conducted on May 3rd, 2019, the following items were removed from the HVA, due to the fact that the facility does not have the corresponding utilities, the emergency is not a regional/community occurrence and/or the emergency is addressed in another strategy: Steam Failure Natural Gas Failure VIP Situation Forensic Admission Radiologic Exposure Infant Abduction <p>Also, two emergencies that the facility has identified were not included in the HVA, namely Active Shooter and Elopement. These emergencies already had strategies completed but were added to the HVA following the May 3rd review.</p>

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NAME OF PROVIDER OR SUPPLIER ONEIDA COUNTY HOSPITAL & LONG TERM CARE FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 150 NORTH 200 WEST MALAD, ID 83252		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 006	Continued From page 2 preparedness plan, including the facility Hazard Vulnerability Assessment (HVA) revealed some of the hazards identified on the HVA did not have strategies for response. When asked, the Administrator stated the facility had only developed strategies for the top 5-10 hazards and was unaware of the need to develop strategies for all hazards identified on the HVA. Reference: 42 CFR 483.73 (a) (1) - (2)	E 006	<ul style="list-style-type: none"> • Identification residents with potential to be affected. All residents and patients have the potential to be affected. • Measures to prevent occurrence. During the review conducted on May 3rd, 2019 by the NHA and the Maintenance Supervisor, the following emergencies listed on the HVA were identified as needing corresponding strategies: Generator Failure Transportation Failure Fuel Shortage Propane Gas Failure Medical Gas Failure Medical Vacuum Failure Information Systems Failure Supply Shortage Fire Alarm Failure Drought Dam Inundation Hazmat Incident (mass/small) Mass Casualty Incident (trauma) Structural Damage to Facility Flood, Internal Strategies for these emergencies will be completed and added to the ERP by June 3rd, 2019. • Monitoring and Quality Assurance The NHA, or designee, will conduct education regarding updates to the facility ERP during Safety Committee Meeting on May 23rd, 2019. Completion of the individual strategies will be reported to the Quality Assurance Committee (QAC) monthly and as needed until a lesser frequency is deemed appropriate. • Completion Date June 3rd, 2019. 	