COPY

IDAHO DEPARTMENT OF
HEALTH & WELFARE

BRAD LITTLE – Governor
DAVE JEPPESEN – Director

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

August 5, 2020

John Williams, Administrator
Oneida County Hospital Home Care
150 North 200 West
Malad, ID 83252

RE: Oneida County Hospital Home Care, Provider #137077

Dear Mr. Williams:

This is to advise you of the findings of the Medicare recertification, including emergency preparedness survey and the focused infection control survey, which was concluded at your facility on July 16, 2020.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction.

An acceptable plan of correction (PoC) contains the following elements:

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the home health agency into compliance, and that the home health agency remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and

- The administrator's signature and the date signed on page 1 of the Form CMS-2567.

After you have completed your Plan of Correction, return the original to this office by **August 18, 2020**, and keep a copy for your records.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Dennis Kelly, RN or Nicole Wisenor, Co-Supervisors, Non-Long Term Care at (208) 334-6626, option 4.

Sincerely,

Dennis Kelly RN

DENNIS KELLY, RN, Supervisor
Non-Long Term Care

DK/nw
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137077	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONEIDA COUNTY HOSPITAL HOME CARE	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
G 000	INITIAL COMMENTS The following deficiencies were cited during the Medicare Recertification Survey, including Emergency Preparedness, and the Federal Medicare COVID-19 Focused Infection Control Survey, conducted at your home health agency on 7/13/20 to 7/16/20. Surveyors who conducted the survey were: Kim Mehlhaff RN, HFS, Team Lead Molly Lorden RN, BSN, HFS Acronyms used in this report include: ADL - Activity of Daily Living ASHD - Arteriosclerotic Heart Disease BG - Blood Glucose BLE - Bilateral Lower Extremity CHF - Congestive Heart Failure CKD - Chronic Kidney Disease CMS - Centers for Medicare & Medicaid Services CNA - Certified Nursing Assistant COPD - Chronic Obstructive Pulmonary Disease COVID-19 - Coronavirus Disease 2019 D/C or d/c - Discharge DM - Diabetes Mellitus DON - Director of Nursing EMR - Electronic Medical Record EMS - Emergency Medical Services EOP - Emergency Operations Plan ER - Emergency Room HFS - Health Facility Surveyor HHA - Home Health Aide HTN - Hypertension IC - Infection Control L/min - Liters per minute LPN - Licensed Practical Nurse MD - Medical Doctor	G 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
JOHN NMN.	MD	8/18/2020

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137077	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONEIDA COUNTY HOSPITAL HOME CARE	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
G 000	Continued From page 1 mg - Milligrams MSW - Medical Social Worker OASIS - Outcome and Assessment Information Set POC - Plan of Care PCP - Primary Care Provider Pt/pt - Patient PT - Physical Therapy PTA - Physical Therapy Assistant QAPI - Quality Assessment and Performance Improvement Program RN - Registered Nurse RNCM - Registered Nurse Case Manager ROC - Resumption of Care SOC - Start of Care SN - Skilled Nursing UTI - Urinary Tract Infection	G 000		
G 536	A review of all current medications CFR(s): 484.55(c)(5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This ELEMENT is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure medications and allergies were reconciled and a medication and allergy list were kept current for 3 of 7 patients (Patients #2, #4, and #5) whose records were reviewed. These failures had the potential to compromise patient safety. Findings include: 1. Patient #4 was an 88 year old female admitted to the agency 7/06/20, with a primary diagnosis of	G 536	*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.*	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137077	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONEIDA COUNTY HOSPITAL HOME CARE	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
G 536	Continued From page 2 a right humerus fracture. Additional diagnoses included pain, weakness, and a history of falling. She received SN, PT, and HHA services. Her record, including the SOC comprehensive assessment, for the certification period 7/06/20 to 9/03/20 was reviewed. Patient #4's record included the SOC comprehensive assessment, signed by the RNCM on 7/06/20. Patient #4's record included a PCP office visit note dated 1/09/20, which was received and scanned into the EMR by the agency on 7/07/20. This visit note included additional information that was not present on the initial referral from the surgeon. The PCP visit note included additional allergies to acetaminophen-hydrocodone, carbamazepine, and Tramadol. The RNCM performed a visit 7/09/20. The current POC and EMR did not reflect the additional allergies shown on the PCP visit note. The RNCM was interviewed on 7/14/20 at 12:50 PM. The RNCM confirmed she had reviewed the PCP visit note, but had not updated the POC and EMR to reflect the additional information. Patient #4's medical record did not included all pertinent allergies. 2. Patient #5 was a 67 year old female admitted to the agency 8/30/19, with a primary diagnosis of HTN. Additional diagnoses included DM Type 2, morbid obesity, and COPD. She received SN, PT, and HHA services. Her record, including the POC, for the certification period of 6/25/20 to current was reviewed. Patient #5's record included a recertification POC	G 536	**Corrective Action Taken:** A review of all patient charts was conducted to determine if all allergies identified in referral documentation had been included on the plan of care. Two patients were identified who had incomplete allergy lists. A review of all patient charts was conducted to determine if all medications were identified for each patient. Two patients were identified who had incomplete medication lists. On August 14, 2020, agency nursing staff was re-educated regarding patient care planning and the patient comprehensive assessment as they relate to allergy identification and patient medication reconciliation. In addition, the policy "Patient Medication Reconciliation", which includes identifying medications in the home and drug-drug interactions, was written and nursing staff have been educated and signed documentation included validating their training. **Identification Process:** All patients are affected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137077	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONEIDA COUNTY HOSPITAL HOME CARE	160 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
G 536	Continued From page 3 dated 6/23/20 and signed by an RN. Her record also included a PCP visit note dated 1/16/20. The PCP visit notes listed additional allergies of Ceftin and Clindamycin that were not on the POC and EMR. During an interview on 7/14/20, beginning at 3:50 PM, the RNCM for Patient #5 confirmed the allergies on Patient #5's POC and EMR did not reflect all the allergies listed on the PCP visit note. The RNCM confirmed she did review the PCP visit notes and updates the POC and EMR as needed. When asked why Patient #5's record did not accurately reflect her medications, the RN replied, "I don't know what happened." Patient #5's medical record did not include all pertinent allergies 3. Patient #2 was an 84 year old female admitted to the agency 8/23/19 with a primary diagnosis of acute kidney failure. Additional diagnoses included hyperkalemia and CKD. She received SN and PT services. Her record, for the certification period 8/23/19 to 10/21/19, was reviewed. She was discharged from the agency 9/04/19 after meeting her goals. a. Patient #2's record included an SOC comprehensive assessment, dated 8/23/19, signed by the RN. It stated, "discussed ...limiting Acetaminophen to <3000 mg daily." Patient #2's medication list did not include acetaminophen. The RN was interviewed on 7/15/20 at 12:54 PM. She confirmed Patient #2's acetaminophen was not on her medication list. b. Patient #2's record included an OASIS-D	G 536	**Monitoring Performance and Effectiveness:** A chart audit checklist has been created to assure allergies are identified and medication reconciliation is complete based on the agency policy. **Responsible Party:** The Clinical Manager, or designee, will review patient admit charts to assure compliance. **Completion Date:** These audits will be conducted with each new patient admit through October 31, 2020 or until compliance has been established.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137077	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONEIDA COUNTY HOSPITAL HOME CARE	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
G 536	Continued From page 4 Discharge assessment, dated 9/04/19, signed by the RN. Under the section titled "Medication status," the note stated, "serious drug-drug interaction with citalopram-omeprazole, citalopram-mirtazapine. No glucose test strips and did not have prescription." In the section titled, "Medications," the note stated, "There were no potential significant medication issues identified since SOC/ROC [start of care/resumption of care] or patient is not taking any medications." It was unclear whether or not there were medication issues identified for Patient #2. The RN was interviewed on 7/16/20 at 10:04 AM. When asked why there was contradicting information in the OASIS-D Discharge assessment for Patient #2, she stated it was a copy forward issue and the contradiction should have been removed. Patient #2's comprehensive assessments did not include all medications she was taking and did not accurately identify medication interactions.	G 536		
G 574	Plan of care must include the following CFR(s): 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential;	G 574	*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.*	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137077	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONEIDA COUNTY HOSPITAL HOME CARE	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
G 574	Continued From page 5 (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician may choose to include. This ELEMENT is not met as evidenced by: Based on medical record review and staff interview, it was determined the POC did not include all medications and diagnoses for 2 of 7 patients (Patients #4 and #7) whose medical records were reviewed. This resulted in incomplete POCs. Findings include: 1. Patient #7 was a 67 year old female admitted to the agency 6/23/20 with a primary diagnosis of dementia. Additional diagnoses included gastroenteritis and COPD. She received SN, PT, and HHA services. Her record, for the certification period 6/23/20 to 8/21/20, was reviewed. Patient #7's medical record included an SOC comprehensive assessment, dated 6/23/20, signed by the RN. The note stated, "Patient reports she wears her oxygen at night." Oxygen was not included on Patient #7's medication list.	G 574	**Corrective Action Taken:** A review of all patient charts was conducted to determine if all diagnoses identified in referral documentation had been included on the plan of care. Twelve patients were identified who had incomplete diagnoses lists. On August14, 2020, agency nursing staff was re-educated regarding patient care planning and the patient comprehensive assessment as they relate to diagnosis identification. Nursing staff have been educated and signed documentation included validating their training. **Identification Process:** All patients are affected. **Monitoring Performance and Effectiveness:** A chart audit checklist has been created to assure diagnoses are identified on the plan of care, based on the agency policy. **Responsible Party:** The Clinical Manager, or designee, will review patient admit charts to assure compliance. **Completion Date:** These audits will be conducted with each new patient admit through October 31, 2020 or until compliance has been established.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137077	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONEIDA COUNTY HOSPITAL HOME CARE	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
G 574	Continued From page 6 The RN was interviewed on 7/16/20 at 10:02 AM. She confirmed Patient #7's oxygen was not added to her medication list. Patient #7's POC did not include oxygen. 2. Patient #4 was an 88 year old female admitted to the agency 7/06/20, with a primary diagnosis of a right humerus fracture. Additional diagnoses included pain, weakness, and a history of falling. She received SN, PT, and HHA services. Her record, including the SOC, for the certification period 7/06/20 to 9/03/20 was reviewed. Patient #4's record included the SOC comprehensive assessment, dated 7/06/20, signed by the RNCM. Patient #4's record also included a PCP office visit note dated 1/09/20, which was received and scanned into the EMR by the agency on 7/07/20. The PCP visit note included an additional diagnosis of Stage 3 CKD. The RNCM performed a SN visit 7/09/20. The current POC and EMR did not reflect the additional diagnosis shown on the PCP visit note. The RNCM was interviewed on 7/14/20 at 12:50 PM. The RNCM confirmed she had reviewed the PCP visit note, but had not updated the POC and EMR to reflect the additional information. Patient #4's POC did not include her diagnosis of Stage 3 CKD.	G 574		
G 642	Program scope CFR(s): 484.65(a)(1),(2) Standard: Program scope. (1) The program must at least be capable of	G 642		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137077	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONEIDA COUNTY HOSPITAL HOME CARE	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
G 642	Continued From page 7 showing measurable improvement in indicators for which there is evidence that improvement in those indicators will improve health outcomes, patient safety, and quality of care. (2) The HHA must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that enable the HHA to assess processes of care, HHA services, and operations. This STANDARD is not met as evidenced by: Based on medical record review, agency policy, incident and infections logs, and staff interview, it was determined the agency failed to ensure quality indicators, such as incidents and infections, were submitted 2 of 7 patients (#1 & #6). This resulted in the inability of the agency to track and analyze processes of care for quality improvement to positively impact health outcomes, patient safety, and quality of care. Findings include: An agency policy, "Incident Reports," reviewed March 2019, was reviewed. The policy stated Incident Report forms are used as a part of the agency's integrated risk management and performance improvement program and that the form must be completed for unusual occurrences. An unusual occurrence was defined as, "any occurrence involving a patient, employee or family member which is not consistent with regular routine, regardless of whether or not there was an apparent injury or other damage..." The policy stated: "Policy Interpretation and Implementation All employees are responsible for submitting Incident Reports as appropriate. Appropriate	G 642	*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.*	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137077	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONEIDA COUNTY HOSPITAL HOME CARE	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
G 642	Continued From page 8 follow-up will be initiated by the Director. When an event occurs, an Incident Report is completed by personnel aware of the occurrence." An agency policy, "Reporting Patient Infections," reviewed June 2019, was reviewed. The policy stated infection reports would be tracked and trended as part of the agency's QAPI program and would be used to improve patient care. The policy stated, "All patients with a suspected infection shall have a patient infection report completed within 24 hours of discovery." These policies were not followed. Examples include: 1. Patient #1 was a 70 year old male admitted to the agency on 12/13/19, with a primary diagnosis of heart failure. Additional diagnoses included chronic pain and COPD. He received SN and PT services. His record, including the POC, for the certification period of 6/10/20 to current was reviewed. Patient #1's record included an SN visit note, dated 3/28/20, signed by the RNCM. The documentation included a note that the patient had been to the ER. This incident was not reflected on the incident log. Patient #1's record also included SN visit notes on 10/02/20, 3/30/20, and 4/03/20 that referenced patient infections, these were not reflected on the infection log. Patient #1's RNCM was interviewed on 7/14/20, beginning at 3:50 PM. She confirmed that incident and infection reports had not been completed for the above referenced occurrences. When asked why an incident report had not been completed for the ER visit, she stated,	G 642	**Corrective Action Taken:** On 8/14/2020, agency nursing staff was re-educated to the policy "Reporting Patient Infections" and clarification made in regards to reporting all infections. Nursing staff have been educated and signed documentation included validating their training. **Identification Process:** All patients are affected. **Monitoring Performance and Effectiveness:** A chart audit checklist has been created to assure all infections are identified and entered into the infection control log as based on the agency policy. **Responsible Party:** The Clinical Manager, or designee, will review patient charts for daily nurse visits to assure compliance. **Completion Date:** These audits will be conducted for each visit through October 31, 2020 or until compliance has been established.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137077	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONEIDA COUNTY HOSPITAL HOME CARE	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
G 642	Continued From page 9 "Sometimes we don't fill out an incident report." When asked what agency policy was for filling out incident reports was, she replied, "I don't know, you will have to ask [DON]." During an interview on 07/15/20, beginning at 10:10 AM, the DON stated that the definition of an incident was an unusual occurrence that included, but was not limited to, "ER visits, falls, and hospitalizations." She confirmed that the required incident report for Patient #1's ER visit and the required infection reports had not been completed. Patient #1's incident and infection reports were not completed as required by policy. 2. Patient #6 was a 90 year old female admitted to the agency 10/30/16 with a primary diagnosis of pneumonia. Additional diagnoses included CHF and Parkinson's Disease. She received SN, PT, and HHA services. Her record, for the certification periods 4/13/20 to 6/11/20 and 6/12/20 to 8/10/20, was reviewed. Patient #6's medical record included an "OASIS-D1 Transfer," dated 6/12/20, signed by the RN. The note stated, "Aide reported she called family and emergency medical assistance. Pt was brought in and admitted." The note stated patient #6 was admitted to an area hospital. The incident report log was reviewed. It did not contain an entry related to Patient #6's hospital admission. The RN was interviewed by phone on 7/15/20 at 12:54 PM. When asked if Patient #6's hospital admission was tracked, she stated, "yes we're	G 642	**Corrective Action Taken:** The "Incident and Accident Report" policy was updated to include clarification of specific situations, i.e., hospitalization, ED visit, falls, which should be reported. On August 14, 2020, agency nursing staff was re-educated to the policy "Incident and Accident Reports" and clarification made in regards to reporting all incidents. Nursing staff have been educated and signed documentation included validating their training. **Identification Process:** All patients are affected. **Monitoring Performance and Effectiveness:** A chart audit checklist has been created to assure all incidents are identified and entered into the incident report log as based on the agency policy. **Responsible Party:** The Clinical Manager, or designee, will review patient charts for daily nurse visits to assure compliance. **Completion Date:** These audits will be conducted through October 31, 2020 or until compliance has been established.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137077	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONEIDA COUNTY HOSPITAL HOME CARE	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
G 642	Continued From page 10 supposed to and I missed that one." During an interview on 07/15/20, beginning at 10:10 AM, the DON stated that a hospitalization qualified as an Incident. Patient #6's hospital admission was not tracked.	G 642		
G 684	Infection control CFR(s): 484.70(b)(1)(2) Standard: Control. The HHA must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that is an integral part of the HHA's quality assessment and performance improvement (QAPI) program. The infection control program must include: (1) A method for identifying infectious and communicable disease problems; and (2) A plan for the appropriate actions that are expected to result in improvement and disease prevention. This STANDARD is not met as evidenced by: Based on IC data review, policy review, and staff interview, it was determined the agency failed to ensure their surveillance screening and education for COVID-19 included all employees. This had the potential to fail to identify possible COVID-19 positive employees that were seeing patients in their homes. An agency policy, "Employee Work Screening for COVID-19," reviewed July 2020, stated, "All employees reporting to work will be screened for	G 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 prepared and/or executed solely because the provisions of federal and state law require it.* **Corrective Action Taken:** On 8/17/2020, the CNA who did not have written documentation of COVID-19 screening was educated to the policy "COVID-19 Employee Work Screening" and she was instructed to start her day at the office with a COVID screening. Signed documentation has been included validating her training. In addition, an email with the "COVID-19 Employee Work Screening" policy has been sent to the physical therapist and the physical therapy aid educating them regarding the expectation of being screened prior to providing services to home health patients. **Identification Process:** All patients are affected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137077	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONEIDA COUNTY HOSPITAL HOME CARE	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
G 684	Continued From page 11 respiratory symptoms and have their body temperature taken as a precautionary measure to reduce the spread of COVID-19." This policy was not followed. The DON was interviewed on 07/15/20, beginning at 10:10 AM, and the agency's COVID-19 Employee Screening Logs were reviewed in her presence. She confirmed that the agency had not been screening a CNA employee and a contracted Physical Therapist and PTA prior to making patient home visits. She also confirmed the agency had not educated the contracted Physical Therapist and PTA on COVID-19. The agency failed to include all employees in the COVID-19 screening and education process.	G 684	**Monitoring Performance and Effectiveness:** An audit will be conducted verifying employee compliance five days a week for two weeks, then three days per week for two weeks, then weekly for one month. to assure compliance to this policy. **Responsible Party:** The Clinical Manager, or designee, will audit employee COVID screenings to assure compliance. **Completion Date:** These audits will be conducted through October 31, 2020 or until compliance has been established.	
G1024	Authentication CFR(s): 484.110(b) Standard: Authentication. All entries must be legible, clear, complete, and appropriately authenticated, dated, and timed. Authentication must include a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the RN failed to ensure all entries in to the clinical record were clear for 1 of 7 patients (Patient #6) whose records were reviewed. This caused an inconsistency in the clinical record. Patient #6 was a 90 year old female admitted to the agency 10/30/16 with a primary diagnosis of pneumonia. Additional diagnoses included CHF	G1024		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137077	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONEIDA COUNTY HOSPITAL HOME CARE	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
G1024	Continued From page 12 and Parkinson's Disease. She received SN, PT, and HHA. Her record, for the certification periods 4/13/20 to 6/11/20 and 6/12/20 to 8/10/20, was reviewed. Patient #6's record included SN visit notes, dated 6/26/20 and 6/29/20, signed by the RN. Under the section titled "Endocrine/Hematologic" both notes had a comment that stated, "Xarelto 10mg daily." In the narrative portion of both notes, they stated, "Teaching to patient r/t [related to] Coumadin therapy." Xarelto and Coumadin are both blood thinning medications and are not typically prescribed in conjunction with one another. It was unclear which of the two medications Patient #6 was taking. The RN was interviewed by phone on 7/15/20 at 12:54 PM. She stated Patient #6 was not taking both medications, and the documentation of both Coumadin and Xarelto was a copy paste issue. The clinical entry was not clear as to which medication Patient #6 was taking.	G1024	*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truths of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it.* **Corrective Action Taken:** The "Medical Record Content Policy" was updated to include direction regarding the copy and paste feature. On 8/17/2020, the RN Case Managers were educated to the policy, specifically in relation to the section "Copy and Paste". Signed documentation has been included validating their training. **Identification Process:** All patients are affected. **Monitoring Performance and Effectiveness:** An audit of patient charts will be conducted verifying employee compliance five days a week for two weeks, then three days per week for two weeks, then weekly for one month. to assure compliance to this policy. **Completion Date:** These audits will be conducted through October 31, 2020 or until compliance has been established.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137077	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONEIDA COUNTY HOSPITAL HOME CARE	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 following deficiencies were cited during the Medicare Recertification Survey, including Emergency Preparedness, of your home health agency conducted on 7/13/20 through 7/16/20. Surveyors conducting the recertification survey were: Kim Mehlhaff, RN, HFS, Team Lead Molly Lorden RN, BSN, HFS Acronyms used in this report include: CMS - Centers for Medicare and Medicaid Services COPD - Chronic Obstructive Pulmonary Disease DM - Diabetes Mellitus DON - Director of Nursing EMR - Electronic Medical Record EOP - Emergency Operations Plan HHA - Home Health Aide HTN - Hypertension OT - Occupational Therapy POC - Plan of Care PT - Physical Therapy RNCM - Registered Nurse Case Manager SN - Skilled Nursing SOC - Start of Care	E 000	RECEIVED AUG 21 2020 FACILITY STANDARDS	
E 017	HHA Comprehensive Assessment in Disaster CFR(s): 484.102(b)(1) [(b) Policies and procedures. The HHA must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must	E 017		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

John Wms. CEO 8/18/20

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137077	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONEIDA COUNTY HOSPITAL HOME CARE	160 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 017	Continued From page 1 be reviewed and updated at least every 2 years.] At a minimum, the policies and procedures must address the following:] (1) The plans for the HHA's patients during a natural or man-made disaster. Individual plans for each patient must be included as part of the comprehensive patient assessment, which must be conducted according to the provisions at §484.55. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the agency failed to ensure that correct priority codes that reflected patient acuity and needs during an Emergency were assigned to patients as part of their Patient Individualized Emergency Plan for 3 of 3 patients that were dependent on Oxygen (Patients #1, #3, and #5) whose records were reviewed. This had the potential to interfere with the agency's appropriate and timely patient care during an emergency event. Findings include: An agency policy, "EMERGENCY OPERATIONS PLAN," with an effective date of June 2020 was reviewed. It included the following section: "MANAGEMENT OF PATIENTS DURING EMERGENCIES... The admission nurse/licensed therapist is responsible for identifying patients with special needs during the admission process and shall document these needs for review during an emergency event. The Case Manager or licensed therapist (per CMS 484.55) shall be responsible for documenting individual emergency plans in	E 017	*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.* RECEIVED AUG 21 2020 FACILITY STANDARDS	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137077	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONEIDA COUNTY HOSPITAL HOME CARE	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 017	Continued From page 2 response to potential natural or man-made disasters for each patient. All patients should be assigned a priority code from 1-4 in accordance with the acuity of their status. Care shall be provided to those patients with priority status as possible during the emergency event. Status is defined as follows: - Level I - Within 24 hours - High Priority Care Needs: * Patients that require specialized ongoing medical care services, i.e.: *High technology *Home infusion therapy *Oxygen dependent *Ventilator dependent -Level II - Within 24-48 hours - High-Moderate Priority Care Needs: * Patients that require ongoing medical and/or personal care services, i.e.: *Diabetic care daily *Wound care daily *Injections daily *Total care/bedbound -Level III - Within 48-72 hours - Moderate Priority Care Needs: * Patients that require moderate to intermittent medical and/or personal care service, i.e.: *Wound care/intermittent *Ambulates with assistance and/or assistive device -Level IV - Within 72-96 hours - Minimal Priority Care Needs: * Patients that require minimal medical and/or personal care services, i.e.:	E 017	**Corrective Actions Taken:** A review of all patient priority codes was conducted to verify correct priority level assignment. Six patients were identified with inaccurate priority code assignment. On 8/12/2020, agency nursing staff was re-educated regarding the current Disaster Planning Patient Classification System. Nursing staff were given copies of the policy for future reference. In addition, they signed the education documentation and expressed understanding of this process. **Identification Process:** All patients are affected. **Monitoring Performance and Effectiveness:** A chart audit checklist has been created to assure correct identification of patient priority level has been identified based on the agency policy. **Responsible Party:** The Clinical Manager, or designee, will review patient admit charts to assure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137077	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONEIDA COUNTY HOSPITAL HOME CARE	160 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 017	Continued From page 3 *Foley changes/monthly *Shower/tub with standby assist" 1. Patient #1 was a 70 year old male admitted to the agency on 12/13/19, with a primary diagnosis of heart failure. Additional diagnoses included chronic pain and COPD. He received SN and PT services. His record, including the POC, for the certification period of 6/10/20 to current was reviewed. Patient #1's record included an SOC comprehensive assessment and a Patient Individualized Emergency Plan, dated 12/13/19, signed by the RNCM. The SOC and EMR identified that the patient was dependent on oxygen, but under Emergency Preparedness in the EMR, Patient #1 was assigned an Emergency Triage level of III. His "Patient Individualized Emergency Plan" had Level II checked for a priority level. 2. Patient #3 was a 80 year old male admitted to the agency on 7/13/20, with a primary diagnosis of multiple rib fractures. Additional diagnosis included a lung contusion. He received SN, OT, and PT services. His record, including the POC, for the certification period of 7/13/20 to current was reviewed. Patient #3's record included an SOC comprehensive assessment and a Patient Individualized Emergency Plan, dated 7/13/20, signed by the RNCM. The SOC and EMR identified that the patient was dependent on oxygen, but under Emergency Preparedness, Patient #3 was assigned an Emergency Triage level of III. His "Patient Individualized Emergency Plan" did not have anything marked for a priority	E 017	**Completion Date:** These audits will be conducted with each new patient admit through October 31, 2020 or until compliance has been established.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137077	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONEIDA COUNTY HOSPITAL HOME CARE	160 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 017	Continued From page 4 level. 3. Patient #5 was a 67 year old female admitted to the agency on 8/30/19, with a primary diagnosis of HTN. Additional diagnoses included DM Type 2, morbid obesity, and COPD. She received SN, PT, and HHA services. Her record, including the POC, for the certification period of 06/25/20 to current was reviewed. Patient #5's record included an SOC comprehensive assessment and a Patient Individualized Emergency Plan, dated 4/24/19, signed by the RNCM. The SOC and EMR identified that the patient was dependent on oxygen, but under the Emergency Preparedness section and on her "Patient Individualized Emergency Plan" she had Level IV noted. During an interview on 7/15/20, beginning at 10:10 AM, the DON confirmed the Priority Level described in the EOP policy was the same as the Emergency Triage Level listed on the SOC and EMR. The DON confirmed that patients #1, #3, and #5 had been assigned an incorrect priority/emergency triage level. The DON stated she did not know if staff had been trained on assigning Priority/Emergency triage levels. During an interview on 7/14/20, beginning at 3:50 PM, the RNCM for Patient #5 confirmed that she was dependent on oxygen and the SOC and EMR listed the incorrect priority/emergency triage level for Patient #5. Lack of identifying patients' priority/emergency triage level put patients at risk during an emergency.	E 017		