STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135062	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oneida County Hospital & Long Term Care Facility	150 North 200 West Malad, ID 83252

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, record review, and staff interview, it was determined the facility failed to ensure the residents and their representatives received assistance to exercise their right to formulate an Advanced Directive. This was true for 2 of 12 residents (Resident #4 and #19) whose records were reviewed for advanced directives. This deficient practice created the potential for harm or adverse outcomes if residents' wishes were not followed or documented regarding their advance care planning. Findings include:The facility's Resident Rights Regarding Treatment and Advance Directives policy, review date 6/5/25, documented: - On admission the facility will determine if the resident has executed an advanced directive, and if not, determine whether the resident would like to formulate an advance directive. - The facility will provide the resident or resident representative information, in a manner that is easy to understand, about the right to refuse medical or surgical treatment and formulate an advance directive. - Upon admission, should the resident have an advance directive, copies will be made and placed on the chart as well as communicated to the staff. Resident #4 was admitted to the facility on [DATE], with multiple diagnoses including stroke and malignant melanoma of the skin (serious form of skin cancer). Resident #4's Idaho Physician Order For Scope of Treat (POST) form documented under Section D- Advanced Directives: The following documents also exist: DPA (Durable Power of Attorney) and DPAHC (Durable Power of Attorney for Healthcare). Resident #4's record did not include a copy of her DPAHC. On 5/11/26 at 3:06 PM, the DON stated Resident #4's paper chart had a form stating she had an advanced directive, but her medical record did not have a copy of her advanced directive and should have had one. Resident #19 was admitted to the facility on [DATE], with multiple diagnoses including atrial fibrillation (a rapid, chaotic, and irregular heartbeat) and major depression. Resident #19's Advanced Directive Questionnaire, under Section II documented - I have an Advanced Directive and Durable Power of Attorney for Health Care. Review of Resident #19's medical record contained an Idaho Statutory Form Power of Attorney. This form stated this power of attorney did not authorize the agent to make healthcare decisions. On 5/12/26 at 12:32 PM, the DON stated that the facility did not realize Resident #19's POA form was for financial and not healthcare power of attorney and was not sure if Resident #19 realized that he did not have a POA for healthcare.

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.

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

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, record review, and staff interviews it was determined the facility failed to ensure appropriate discharge planning was documented in the resident's medical record and appropriate resident information was communicated to the resident's representative for 1 of 1 resident (Resident #27) reviewed for discharge. This deficient practice had the potential to result in adverse outcomes or harm if the resident did not receive appropriate care after discharge. Findings include: The facility's Discharge Summary policy approved date 4/22/25, documented it is the policy of the facility to ensure that a discharge summary is provided upon a resident's discharge which addresses each resident's discharge goals and needs, including caregiver support and referrals to local contact agencies. Resident #27 was admitted to the facility on [DATE], with multiple diagnoses including dementia and Parkinsonism. A progress note dated 3/31/26 at 11:06 AM, documented staff reported Resident #27 had a fever (101.4 F) without other associated symptoms. Fever of unclear source. Plan: Obtain urinalysis and urine culture. Monitor closely for development of additional symptoms (respiratory, urinary, skin). A progress note dated 3/31/26 at 5:30 PM, documented Resident #27 was picked up by his wife. She grabbed all his belongings and all his medications. Resident #27's vital signs were within normal limits and he was very excited to be going home. Resident's wife signed paperwork for discharge and walked resident out. On 5/12/26 at 2:11 PM, the DON provided the Discharge Instruction form that family had signed on discharge for Resident #27 dated 3/31/26. The form documented the following:-Regular diet-Activity: Resume as normal-Shower: YDriving Restrictions: N/ADisposition: Home and Home Care NurseWound Care: N/ASpecial Instructions: Follow HHMedication: As Prescribed Resident #27 care plan did not document his discharge plan or goals. Resident #27's medical record did not document discharge planning was discussed with resident or family. No discharge summary completed. On 5/12/26 at 1:33 PM, the DON stated she was not sure if there was a discharge summary or charting done for Resident #27. On 5/12/26 at 2:14 PM, the DON stated Resident #27 did not have the proper discharge documentation in his medical record and they could improve on this process.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and policy review it was determined the facility failed to refer residents for recommended further evaluation when residents were diagnosed with a major mental illness. This was true for 1 of 2 residents (Resident #2) reviewed for Pre-admission Screening and Resident Review (PASRR) Level II evaluations. This deficient practice had the potential to cause harm if residents' PASRR Level II recommendations for specialized services needs were not referred for evaluation and incorporated in the resident's care. Findings include:The facility's Resident Assessment - Coordination with PASRR Program policy, dated 8/18/25, documents 7. Recommendations, such as any specialized services, from a PASRR Level II determination and/or PASRR evaluation report will be incorporated into the resident's assessment, care planning, and transitions of care. Resident #2 was admitted to the facility on [DATE], with multiple diagnoses which included alcohol dependence with alcohol-induced persisting dementia and diabetes.Resident #2's comprehensive care plan, initiated on 4/14/26, documented Resident #2 was prescribed antipsychotic medication and thiamine related to her diagnosis of alcohol-induced persisting dementia.Resident #2's medical record documented she had a completed PASRR Level I and Level II screening evaluation from the state-designated authority. However, the PASRR Level II's recommended substance use evaluation was not followed up on and Resident #2's medical record had not documented a reason for failure to follow the state-designated authority's recommendation.On 5/12/26 at 2:58 PM, the LCSW stated the facility did not have a substance use evaluation for Resident #2 or had documented why it was not obtained.On 5/12/26 at 4:17 PM, the DON stated Resident #2 had not been referred for the substance use evaluation as recommended on the PASRR Level II and should have been.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and policy review it was determined the facility failed to refer residents for further evaluation when residents were diagnosed with a major mental illness. This was true for 1 of 2 residents (Resident #1) reviewed for Pre-admission Screening and Resident Review (PASRR) Level I and Level II evaluations. This deficient practice had the potential to cause harm if residents' specialized services for mental health needs were not evaluated by an appropriate state-designated authority. Findings include: The facility's Resident Assessment - Coordination with PASRR Program policy, dated 8/18/25, documents 1. All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions.a. PASRR Level I - initial pre-screening that is completed prior to admission.2. The facility will only admit individuals with a mental disorder or intellectual disability who the State mental health or intellectual disability authority has determined as appropriate for admission.Resident #1 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses which included dementia and Post-Traumatic Stress Disorder (PTSD). Resident #1's care plan, created on 12/5/23, documented Resident #1's diagnosis of dementia and PTSD. Resident #1's admission MDS (Minimum Data Set - an assessment used to identify the resident's clinical condition, cognitive and functional status, and use of services), completed on 12/13/23, documented PTSD. Resident #1's medical record documented her PTSD diagnosis (major mental illness). On 5/11/26 at 3:07 PM, Resident #1's PASARR Level I had not documented her diagnosis of PTSD (major mental illness). Therefore, Resident #1's medical record had not documented the completion of PASRR Level II. On 5/12/26 at 3:08 PM, the LCSW stated the facility should have completed Resident #1's PASRR Level I with her PTSD diagnosis and submitted a PASRR Level II to the state-designated authority but had not.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, staff interviews, and policy review it was determined the facility failed to ensure that prior to the placement of bed rails, a resident assessment was completed that included alternatives to bed rail use were attempted and how the alternatives failed to meet the resident's assessed needs.This was true for 1 of 12 residents (Resident #3) reviewed for bed rails.This failure created the potential for harm due to the risk for injury, entrapment and/or death. Findings include:The facility's Proper Use of Bed Rails policy, reviewed date 6/5/25, documented.Policy Explanation and Compliance Guidelines: Resident Assessment 2. The resident assessment must include an evaluation of the alternatives that were attempted prior to the installation or use of a bed rail and how these alternatives failed to meet the resident's assessed needs. 3. The resident assessment must also assess the resident's risk from using bed rails. 6. Informed consent from the resident or resident representative must be obtained after appropriate alternatives have been attempted prior to installation and the use of bed rails. 8. Upon receiving informed consent, the facility will obtain a physician's order for the use of the specified bed rail and medical diagnosis, condition, symptom, or functional reason for the use of the bed rail.Resident #3 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses which included Schizophrenia (a mental disorder characterized by disturbances of thinking, mood, and behavior) and depression.On 5/11/26 and 5/12/26, observed Resident #3 with one upper bed rail on his bed and in the up position.On 5/12/26 at 10:05 AM, review of Resident #3's medical record had not documented the resident assessment, evaluation of the alternatives attempted or documentation of the purpose of the intended use of the bed rails, a physician order for bed rails, or documented discussion of risks and benefits with a signed consent for use of bed rails.On 5/12/26 at 1:42 PM, the DON stated Resident #3 had not been assessed for the use of bed rails and should not have had the bed rail in use but had. The DON confirmed the policy was not followed.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on staff interview and review of employee personnel files, it was determined the facility failed to ensure each CNA's annual performance review was completed at least once every 12 months for 2 of 2 CNAs (#1and #2) whose personnel records were reviewed for sufficient and competent staffing. This failure created the potential for incompetent CNAs providing care and increased the risk for harm for all residents living in the facility. Findings include:On 5/13/26 at 10:17 AM, review of CNA #1's employee file documented her initial hire date was 10/18/23.CNA #1's employee file did not have documentation that an annual performance review had been done.On 5/13/26 at 10:25 AM, review of CNA #2's employee file documented her initial hire date was 4/24/09.CNA #2's employee file did not have documentation that an annual performance review had been done.On 5/13/26 at 10:48 AM, the HR Director stated the CNAs annual performance reviews had not been provided to her to include in the personnel files.On 5/13/26 at 10:52 AM, the DON stated the CNAs annual performance reviews had not been completed but should have been.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, staff interviews, and the State Operations Manual, Appendix PP it was determined the facility failed to ensure nurse staffing information was accurate, posted daily for each shift, and included scheduled and actual hours. This failed practice had the potential to affect the 23 residents residing in the facility and their representatives, visitors, and others who wanted to review the facility's staffing levels. Findings include:State Operations Manual, Appendix PP revised on 7/23/25, documents.the facility posts the following information on a daily basis: facility name, current date, total number and actual hours worked by licensed and unlicensed nursing staff, and resident census. On 5/12/26 at 1:40 PM, the daily posted staffing sheets were reviewed for the months of November 2025 - May 2026, the following was observed:-No facility resident census included on the sheets for the 7 months reviewed -No weekend (Saturday and Sunday) daily posted staffing sheets completed for the 7 months reviewed -No actual licensed and unlicensed staff hours documented on the sheets for the 7 months reviewed On 5/12/26 at 2:41 PM, the DON stated the facility had not documented the resident census and the actual licensed and unlicensed staff hours on the daily posted staffing sheets prior to her arrival as the DON and the practice had continued but should not have.On 5/12/26 at 2:45 PM, the DON stated the facility had not completed weekend daily posted staffing sheets prior to her arrival as the DON and the practice had continued but should not have.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, staff interview, and policy review it was determined the facility failed to ensure infection control prevention practices were maintained to provide a safe and sanitary environment. This was true for 1 of 5 residents (Resident #15) observed for infection control. These failures put residents at risk for cross contamination and infection. Findings include: The facility's Oxygen Administration and Monitoring policy dated 9/29/25, documented Policy Interpretation and Implementation 5. Keep delivery devices covered in plastic bag when not in use.Resident #15 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses which included chronic obstructive pulmonary disease (disease process which causes decreased ability of the lungs to perform their function) and heart failure. A physician order dated 3/11/25, documented Resident #15 was to wear her CPAP machine (provides positive airway pressure to help breathing) every night related to her obstructive sleep apnea. On 5/11/26 at 10:58 AM, and 5/12/26 at 9:46 AM, Resident #15's CPAP mask and tubing were observed to be placed in her bed on top of the bed linen. The equipment was not bagged. On 5/12/26 at 1:38 PM, the DON stated the CPAP equipment should not have been in the bed and should have been stored appropriately and placed in a plastic bag when not in use.