IDAHO DEPARTMENT OF

HEALTH & WELFARE

JAMES E. RISCH – Governor
KARL B. KURTZ – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7000 1670 0011 3314 9092

August 18, 2006

Sharon Galindo, Administrator
Shoshone Rehabilitation & Living Center
511 East Fourth Street, P.O. Box B
Shoshone, ID 83352

Provider #: 135056

Dear Ms. Galindo:

On **August 8, 2006**, a fire safety survey was conducted at Gooding Rehabilitation & Living Center by the Bureau of Facility Standards/Department of Health & Welfare 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 in your facility to be a pattern of deficiencies that constitute no actual harm, but have potential for more than minimal harm and are not an immediate jeopardy, as evidenced by the attached CMS Form 2567L whereby corrections are required.

Enclosed is a Statement of Deficiencies/Plan of Correction, CMS Form 2567L, listing Medicare/Medicaid deficiencies, and a similar form 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/State Tag in column X5 (Complete 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 "Date Certain" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign both the CMS Form 2567L and State Statement of Deficiencies, in the spaces provided, and return the originals to this office.**

Your Plan of Correction (PoC) for the deficiencies must be submitted by **August 31, 2006**. Failure to submit an acceptable PoC by **August 31, 2006**, may result in the imposition of civil monetary penalties by **September 20, 2006**.

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.

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

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS), if your facility has failed to achieve substantial compliance by **September 12, 2006 (Date Certain)**. Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **September 12, 2006**. A change in the seriousness of the deficiencies on **September 12, 2006**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **September 12, 2006** includes the following:

Denial of payment for new admissions effective **November 8, 2006**. [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 **February 8, 2007**, 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 me with your written credible allegation of compliance at the following address:

Bureau of Facility Standards — DHW

3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036

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 **August 8, 2006** 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 the opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send a written request which states the specific deficiencies being disputed, and explains why you are disputing those deficiencies. This request must be received by **August 31, 2006**.

All required information should be as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10.pdf
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/2001_10_attach1.pdf

If your request for informal dispute resolution is received after **August 31, 2006**, 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.

Sincerely,

MARK P. GRIMES
Supervisor
Facility Fire Safety and Construction

MPG/dmj

Enclosures

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

PRINTED: 08/17/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135056	A. BUILDING 01 - ENTIRE BUILDING B. WING _____	08/08/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOSHONE REHAB & LIVING CENTER	PO BOX 830 SHOSHONE, ID 83352

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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 V(111) construction and was built in 1958. It is fully sprinklered building and has smoke detection coverage in hallways and open areas. Also quick response sprinklers are installed in the new entrance and the new addition of the dining room. Currently the facility is licensed for 39 beds with a census of 34 residents. The following deficiencies were cited at the above facility during the annual Fire/Life Safety survey conducted on 8 August, 2006. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, adopted 11 March, 2003. In accordance with CFR 42, 483.70. The Survey was conducted by: Chris Laumann, Health Facility Surveyor	K 000	RECEIVED AUG 29 2006 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sharon Saenz TITLE: Admin. (X6) DATE: 8/25/06

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

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K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observations during a facility tour it was determined that the facility failed to ensure the proper closure and latching of corridor doors. 2 of 34 residents were effected. The finding included: 1. During a facility tour of the facility in the morning of August 7, 2006 at 10:30 AM, the door to room 17 was observed to not properly close and latch. Observations were witnessed and noted by surveyor and facility maintenance supervisor.	K 018	A proper closing and latch plate was installed on room 17 All Resident doors were checked for proper closure Resident doors will be checked every month by the maintenance/designee and the results of this check will be reviewed in CQI monthly X three months to ensure compliance	20 Aug 2006 as per phone conversation w/ Sharon on 1 Sept 2006

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K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure that all doors in smoke barriers seal against the passage of smoke. This deficient practice affected residents and staff within two of four smoke compartments. The facility had a census of 34 residents. Findings include: 1. During the facility tour on 8 August, 2006, it was observed by surveyor and maintenance staff at 11:00 AM that the smoke doors located adjacent to the dining area nurses station, when closed, did not create a smoke tight barrier due to a severe warp in the door which left a 2 inch gap at the top of the door, compromising the integrity of the required smoke tight seal.	K 027	The NuVu Engineer checked the fire doors on 8-8-06 and again on 8-10-06. Although the doors currently meet compliance for a smoke barrier it was found the doors and frame have been repaired so many times that it is beneficial to the Residents to have new fire doors installed. The Administrator has special ordered replacement fire doors. These are anticipated to arrive and be installed within the next three (3) weeks.	20 August 2006 as per phone conversation w/ Sharon on Sept 1 2006

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K 144 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based upon a review of available documentation and interview with the Engineering Director on 7 August, 2006, the facility did not assure that the Essential Electrical System (i.e., emergency power) was being tested routinely as required. The facility had a census of 34 residents, as well as staff, all of whom were potentially effected. Findings Include: A review of preventive maintenance records on the day of the survey at 12:10 PM revealed that no documentation of generator testing existed. Interview with the maintenance engineer on the day of the survey revealed that the testing had been done, but the documentation was misplaced.	K 144	A new maintenance person has been hired. He has at this time met compliance by initiating a preventative maintence record for the generator along with completing generator tests. Maintenance will bring the generator log to the monthly safety meeting to ensure compliance	20 August 2006 as per phone conversation on 1 Sept 2006

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K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observations it was determined that the facility failed to ensure compliance with electrical safety regulations. Three kitchen staff present at the time of the survey were in danger of electrocution and potential exposure to fire. Findings include: 1. Observation on 8 August, 2006 at 11:00 AM, disclosed that an electrical panel door located in the Kitchen did not secure or latch, as required by NFPA 70, 1.1.110.27, National Electrical Code All finding were observed and noted by surveyor and maintenance supervisor.	K 147	Electrical Contractors Inc. out of Jerome came to the facility 8-14-06 and inspected the wiring and applied secure locks to all electrical panel doors. The electrical panel in the kitchen was repaired providing full secure closure/latch All electrical panels in the facility were checked and full secure closure was noted All electrical panels have a sign indicating *to be closed at all times.*	26 August 2006 As per phone conversation on 1 Sept 2006

Bureau of Facility Standards

PRINTED: 08/17/2006
FORM APPROVED

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C 000	INITIAL COMMENTS The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2. The facility is a single story, type V(111) construction and was built in 1958. It is fully sprinklered building and has smoke detection coverage in hallways and open areas. Also quick response sprinklers are installed in the new entrance and the new addition of the dining room. Currently is licensed for 39 beds with a census of 34 residents. The following deficiencies were cited during the annual Fire Life Safety survey conducted on 8 August, 2006. The facility was surveyed under IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities. The Survey was conducted by: Chris Laumann, Health Facility Surveyor	C 000		
C 230	02.106,02,b b. Existing facilities licensed prior to the effective date of these rules, regulations and minimum standards and in compliance with a previous edition of the Life Safety Code may continue to comply with the edition in force at that time. This Rule is not met as evidenced by:	C 230	Refer to K144, K147	20 Aug 2006 as per phone conversation on 1 Sept 2006

RECEIVED
AUG 29 2006
FACILITY STANDARDS

Bureau of Facility Standards

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

TITLE Admin.

(X6) DATE 8/25/06

STATE FORM 6899 QXKK21

If continuation sheet 1 of 2

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135056	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 -ENTIRE BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/08/2006
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C 230	Continued From page 1 Refer to federal tags K 0018 which refers to corridor doors, K 0027 which refers to fire doors, K 0144 which refers to generator documentation, and K 0147 which refer's to electrical code requirements. All federal K tags are documented on CMS-2567.	C 230		
C 266	02.106,10,c c. All fuel-fired heating devices shall have an easily accessible, plainly marked, functional remote fuel shut-off valve. This Rule is not met as evidenced by: Based on observation, it was determined that the facility failed to ensure that the main utility fuel shut off valve was plainly marked and easily identifiable. The finding included: 1.) During a facility tour of the facility on the afternoon of 7 August, 2006, at 12:00 PM it was observed that the exterior main utility fuel shut-off valve was not plainly marked and easily identifiable. Observations were witnessed and noted by surveyor and facility maintenance supervisor.	C 266	The exterior main utility fuel shut-off valve has been painted red and a sign is located at the site for further identification	20 August 2006 as per phone conversation on 1 Sept 2006