



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – 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

August 20, 2015

Bonnie Sorensen, Administrator
Countryside Care & Rehabilitation
1224 Eighth Street
Rupert, ID 83350-1527

Provider #: 135064

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

Dear Ms. Sorensen:

On **August 10, 2015**, a Facility Fire Safety and Construction survey was conducted at **Countryside Care & Rehabilitation** 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

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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 **September 2, 2015**. Failure to submit an acceptable PoC by **September 2, 2015**, may result in the imposition of civil monetary penalties by **September 21, 2015**.

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 and the state licensure survey report, State Form.

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 14, 2015**, (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 **September 14, 2015**. A change in the seriousness of the deficiencies on **September 14, 2015**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **September 14, 2015**, includes the following:

Denial of payment for new admissions effective **November 10, 2015**.
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 10, 2016**, 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 Mark P. Grimes, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, 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 **August 10, 2015**, 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:

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<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 **September 2, 2015**. If your request for informal dispute resolution is received after **September 2, 2015**, 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/lj
Enclosures

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

Printed: 08/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135064	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 08/10/2015
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NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE CARE & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 1224 8TH STREET RUPERT, ID 83350
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	INITIAL COMMENTS The main Extended Care Facility is a single story, type V(111) construction, with a two hour wall at the 1960 original hospital building. The short term (west unit) portion of the nursing facility occupies a wing of the Hospital building and is separated by a smoke barrier from the remaining hospital building which is type I construction. The entire facility is fully sprinklered with corridor smoke detection and manual fire alarm system. The facility is licensed for 46 SNF beds. The following deficiencies were cited during the annual Life Safety Code Survey conducted on August 10, 2015. The facility was surveyed under the 2000 Life Safety Code, Existing Health Care Occupancies in accordance with 42 CFR 483.70(a). The survey was conducted by: Nathan Elkins Health Facility Surveyor Facility Fire Safety & Construction	K 000		
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4	K 025		

RECEIVED
SEP - 1 2015
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Bonnie Sorenson</i>	TITLE RN LNHA	(X6) DATE 8-28-15
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 025	Continued From page 1 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that smoke barriers were maintained. Failure to maintain smoke barriers could allow smoke and dangerous gases to pass freely between smoke compartments during a fire event. This deficient practice affected no residents, staff and visitors on the date of survey. The nursing facility is licensed for 46 SNF beds with a census of 43 on the day of the survey. Findings Include: 1.) During the facility tour on August 10, 2015 at approximately 11:00 AM, observation of the East shower room ceiling revealed a conduit pipe passing through an unsealed 2 inch circular hole that would not provide at least a one half hour fire resistance rating. When asked, the maintenance supervisor stated the facility was unaware of the unsealed penetration. 2.) During the facility tour on August 10, 2015 at approximately 12:00 PM, observation above the cross corridor doors near the front entrance revealed three 3 inch pipes penetrating through the smoke barrier that were unsealed and would not provide at least a one half hour fire resistance rating. When asked, the maintenance supervisor stated the facility was unaware of the unsealed pipes. Actual NFPA reference: 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at	K 025	K-025 Corrective Action: The identified areas: <ul style="list-style-type: none"> • East Shower room ceiling: 2 inch circular hole was filled with fire retardant foam. • Above cross corridor doors near the front entrance: fire retardant foam was used to fill unsealed areas around the 3 inch pipes. Maintenance Supervisor is aware of the NFPA 101 standard. Systemic changes – Maintenance Supervisor, or designee, will do a facility walk through at least quarterly to monitor for penetrations in the smoke barriers. Quality Assurance - Maintenance Supervisor, or designee, will report monitors to the facility's Safety Committee quarterly, beginning September 2015.	8/28/15

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K 025	<p>Continued From page 2</p> <p>an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor.</p> <p>Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 has been provided for smoke compartments adjacent to the smoke barrier.</p> <p>8.3.2* Continuity. Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces.</p> <p>Exception: A smoke barrier required for an occupied space below an interstitial space shall not be required to extend through the interstitial space, provided that the construction assembly forming the bottom of the interstitial space provides resistance to the passage of smoke equal to that provided by the smoke barrier.</p> <p>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (1) The space between the penetrating item and the smoke barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke</p>	K 025		

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K 025	Continued From page 3 barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (3) Where designs take transmission of vibration into consideration, any vibration isolation shall meet one of the following conditions: a. It shall be made on either side of the smoke barrier. b. It shall be made by an approved device that is designed for the specific purpose.	K 025		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the fire suppression system was maintained in accordance with NFPA 25. Failure to provide maintenance of the sprinkler system could result in an ineffective water pattern from the sprinkler heads during a fire event. This deficient practice affected all residents, staff and visitors on the date of the survey. The nursing facility is licensed for 46 SNF beds with a census	K 062		

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K 062	<p>Continued From page 4 of 43 on the day of the survey.</p> <p>Findings Include:</p> <p>During the facility tour on August 10, 2015 at approximately 11:30 AM, observation of the East Dining Room revealed multiple sprinkler heads loaded with excessive dust build up. When asked, the Maintenance Supervisor stated the facility was unaware of the dusty sprinkler heads.</p> <p>Actual NFPA reference: NFPA 25, 2-2.1.1*</p> <p>Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.</p> <p>Exception No. 1*: Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection.</p> <p>Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown.</p>	K 062	<p>K 062</p> <p>Corrective Action: The identified areas:</p> <ol style="list-style-type: none"> 1. East Dining Room: The excessive dust build up was removed from multiple sprinkler heads. <p>Maintenance Supervisor is aware of the NFPA 101 standard.</p> <p>Systemic changes – Staff was inserviced on cleaning sprinkler heads.</p> <p>Monitor – Nursing Home Administrator, or designee, will do a facility walk through at least monthly to monitor for excessive dust build up on sprinkler heads.</p> <p>Quality Assurance - Maintenance Supervisor, of designee will report to the facility's Safety Committee quarterly, beginning September 2015.</p>	8/28/15
K 147 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure proper clearance around electric circuit breakers was in accordance with the National Electrical Code. This deficient practice affected no residents, staff and visitors on the</p>	K 147		

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K 147	<p>Continued From page 5 date of survey. The facility is licensed for 46 SNF beds with a census of 43 the day of survey.</p> <p>Findings Include:</p> <p>During the facility tour on August 10, 2015 at approximately 12:00 PM, observation of the storage room near the Administration office and Director of Nursing office revealed multiple wheel chairs blocking the electrical breaker panels. When asked, the maintenance supervisor stated the facility was unaware of the blocked electrical panels.</p> <p>Actual NFPA reference: NFPA 70.110.26 Spaces About Electrical Equipment.</p> <p>Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.</p> <p>(2) Width of Working Space. The width of the working space in front of the electric equipment shall be the width of the equipment or 750 mm (30 in.), whichever is greater. In all cases, the work space shall permit at least a 90 degree opening of equipment doors or hinged panels</p>	K 147	<p>K 147</p> <p>Corrective Action: The identified areas:</p> <ol style="list-style-type: none"> I. Storage room near the Administration office and Director of Nursing office: Caution/barrier tape was installed in area around electrical panels to prevent storage blocking electrical panels. <p>Systemic Change: Staff was inserviced about storage not being permitted inside taped off area.</p> <p>Monitor: Nursing Home Administrator, or designee will routinely monitor taped area to assure that electrical panels are not blocked.</p> <p>Quality: Maintenance Supervisor will report to the facility's Safety Committee quarterly, beginning in September 2015.</p>	8/28/15