



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

Rod Jacobson, Administrator
Bear Lake Memorial Skilled Nursing Facility
164 South Fifth Street
Montpelier, ID 83254-1557

Provider #: 135070

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

Dear Mr. Jacobson:

On **August 11, 2015**, a Facility Fire Safety and Construction survey was conducted at **Bear Lake Memorial Skilled Nursing Facility** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be one that comprises a pattern 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 22, 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 15, 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 15, 2015**. A change in the seriousness of the deficiencies on **September 15, 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 15, 2015**, includes the following:

Denial of payment for new admissions effective **November 11, 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 11, 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 11, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135070	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE NF B. WING _____	(X3) DATE SURVEY COMPLETED 08/11/2015
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NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL SKILLED NURSING F	STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254
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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	<p>INITIAL COMMENTS</p> <p>The facility is a single story type V (111) construction, fully sprinklered and built in 1977. The nursing facility is separated from the existing hospital by a two hour fire separation wall. The nursing facility has two smoke compartments. The facility is currently licensed for 36 SNF/NF beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on August 11, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.</p> <p>The Survey was conducted by:</p> <p>Nathan Elkins Health Facility Surveyor Facility Fire Safety & Construction</p>	K 000	<p>The alleged deficiency K 011 specifically found an unsealed 1 inch pipe and unsealed 2 inch pipe penetrating through the fire wall. In addition, fire stop pillows were loosely stacked, allowing open penetrations through the wall. The deficiency will be corrected as follows:</p> <p>First: The maintenance supervisor will cap and seal both the 1 and 2 inch pipes. In addition, the "fire stop" pillows will be secured so that all penetrations are eliminated.</p>	
K 011 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2</p> <p>This Standard is not met as evidenced by: Based on observation and interview the facility failed to ensure the 2 hour fire rated wall that separated the hospital and the skilled nursing facility was maintained without penetrations. Failure to maintain the 2 hour fire separation wall</p>	K 011	<p>Second: The maintenance supervisor will perform an inventory of the area for similar issues, especially in zones of current and past construction projects.</p> <p>Third: In the future, the maintenance supervisor will inventory fire walls during and after new construction and facility remodels to ensure similar penetrations are eliminated.</p> <p>Fourth: The maintenance supervisor will oversee and</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Nathan Elkins</i>	TITLE <i>Admiral</i>	(X8) DATE <i>8-27-15</i>
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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.

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135070	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE NF B. WING _____	(X3) DATE SURVEY COMPLETED 08/11/2015
NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL SKILLED NURSING F		STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 011	<p>Continued From page 1</p> <p>could allow fire and smoke to penetrate through the wall and endanger both occupancies. This deficient practice affected 18 residents, staff and visitors on the date of the survey. The facility is licensed for 36 SNF/NF beds with a census of 32 on the day of the survey.</p> <p>Findings Include:</p> <p>During the facility tour conducted on August 11, 2015 at approximately 11:00 AM, observation of the 2-hour fire wall separating the skilled nursing facility and the hospital above the drop down ceiling revealed an unsealed 1 inch pipe and an unsealed 2 inch pipe penetrating through the wall. Upon further investigation on the hospital side of the 2-hour fire wall revealed fire stop pillows loosely stacked that showed open penetrations through the wall. When asked, the Maintenance Supervisor stated he was unaware of the penetrations in the 2-hour fire wall.</p> <p>Actual NFPA standard: 19.1.2.1* Sections of health care facilities shall be permitted to be classified as other occupancies, provided that they meet all of the following conditions: (1) They are not intended to serve health care occupants for purposes of housing, treatment, or customary access by patients incapable of self-preservation. (2) They are separated from areas of health care occupancies by construction having a fire resistance rating of not less than 2 hours</p>	K 011	<p>perform routine inspections of the fire walls to ensure that no penetrations are present. The maintenance department will keep a record of inventories, problems, and corrections made.</p> <p>Lastly, the corrective action will be completed by 9/2/15</p>	
K 025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may</p>	K 025		

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K 025	<p>Continued From page 2</p> <p>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</p> <p>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 18 residents, staff, and visitors on the date of survey. The facility is licensed for 36 SNF/NF beds with a census of 32 on the day of the survey.</p> <p>Findings include:</p> <p>1.) During the facility tour conducted on Aug 11, 2015 between 10:30 AM and 2:00 PM, observation of the Lounge closet ceiling revealed a 2 inch by 2 inch circular hole and a 3 inch rectangular hole in the ceiling that would not resist the passage of smoke. When asked, the Maintenance Supervisor stated the facility was unaware of the holes in the ceiling.</p> <p>2.) During the facility tour conducted on Aug 11, 2015 between 10:30 AM and 2:00 PM, observation of the mechanical room on the south east side of the facility revealed a 10 inch by 3 inch rectangular hole cut into the ceiling that would not resist the passage of smoke. When</p>	K 025	<p>The alleged deficiency K 025 points out that the standard to ensure that smoke barriers are maintained was not met as evidenced by a 2 inch by 2 inch circular hole and a 3 inch rectangular hole in the ceiling that would not resist the passage of smoke in the lounge closet ceiling. In addition, a 10 inch by 3 inch rectangular hole cut into the ceiling in the mechanical room was observed that would not resist the passage of smoke.</p> <p>The deficiency will be corrected as follows:</p> <p>First: The maintenance supervisor will seal the holes in the lounge closet and mechanical room in order to resist the passage of smoke as outlined in this standard.</p> <p>Second: The maintenance supervisor will perform an inventory of the area for similar issues, especially in zones of current and past construction projects.</p>	

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K 025	<p>Continued From page 3</p> <p>asked, the Maintenance Supervisor stated the hole was cut into the ceiling for the addition of a dry pipe sprinkler system that was installed for the outside over hang of the southeast exit.</p> <p>Actual NFPA standard: 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 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. 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. 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>	K 025	<p>Third: In the future, the maintenance supervisor will inventory the area during and after new construction and facility remodels to ensure similar smoke passages are prevented.</p> <p>Fourth: The maintenance supervisor will oversee and perform routine inspections of the facility to ensure that no smoke passages are present. The maintenance department will keep a record of inventories, problems, and corrections made.</p> <p>Lastly, the corrective action will be completed by 9/2/15</p>	

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K 072 K 072 SS=D	Continued From page 4 NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure that means of egress was maintained free from obstructions. Failure to provide exit access free of obstructions could prevent the safe evacuation of occupants during an emergency. This deficient practice affected 5 staff members and visitors on the day of survey. The facility is licensed for 36 SNF/NF beds with a census of 32 on the day of survey Findings Include: During the facility tour on August 11, 2015 at approximately 10:00 AM, observation of the administration offices corridor revealed a large paper shredder blocking the exit access. Upon further investigation at 2:00 PM, observation revealed the paper shredder was still blocking the exit access from the administration offices. When asked, the Maintenance Supervisor and the Administrator stated the facility was unaware the paper shredder was blocking the means of egress. Actual NFPA Standard: NFPA 101, 7.1.10 Means of Egress Reliability. 7.1.10.1*	K 072 K 072	The alleged deficiency K 072 points out that the standard to continuously maintain a means of egress was not met as evidenced by a paper shredder blocking the exit access from the administration offices. The deficiency will be corrected as follows: First: The administrator will remove the shredder from the administrative office exit access and place it in an office away from an egress. Second: The administrator will coordinate an inventory of the areas other means of egress with the QA team for similar problems. Third: In the future, the administrator will coordinate routine inspections of the facility with the QA team to ensure means of egress are continuously maintained, free of all obstructions or impediments to full instant use in the case of fire or other emergency.	

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K 072	Continued From page 5 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency	K 072	Fourth: The results of the means of egress inventories will be reported in the facilities weekly QAPI meeting to ensure the deficient practice will not recur. Lastly, the corrective action will be completed by 9/2/15	