



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 Eder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

August 20, 2015

Steve Gannon, Administrator
Quinn Meadows Rehabilitation & Care Center
1033 West Quinn Road
Pocatello, ID 83202-2425

Provider #: 135136

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

Dear Mr. Gannon:

On **August 12, 2015**, a Facility Fire Safety and Construction survey was conducted at **Quinn Meadows Rehabilitation & Care Center** 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 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 23, 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 23, 2015**. A change in the seriousness of the deficiencies on **September 23, 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 23, 2015**, includes the following:

Denial of payment for new admissions effective **November 12, 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 12, 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 12, 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

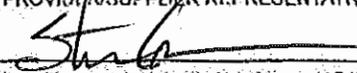
Printed: 08/19/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135136	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - QUINN MEADOWS B. WING _____	(X3) DATE SURVEY COMPLETED 08/12/2015
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NAME OF PROVIDER OR SUPPLIER QUINN MEADOWS REHABILITATION & CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1033 WEST QUINN ROAD POCATELLO, ID 83202
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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 approximately 26,000 square foot of type V (111) construction subdivided into two smoke compartments, there is an attached Physical Therapy office separated by two hour construction. The building is sprinklered with corridor smoke detection and manual fire alarm system. Emergency power is provided by an onsite generator system. The facility is currently licensed for 41 beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on August 12, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, New Health Care Occupancy, in accordance with 42 CFR, 483.70.</p> <p>The surveyor conducting the survey was:</p> <p>Nathan Elkins Health Facility Surveyor Facility Fire Safety & Construction</p>	K 000	<p>Preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the accuracy or truthfulness of any facts alleged or any conclusions set forth in this allegation of deficiencies by the State Licensing Authority. Accordingly, the facility has drafted this Plan of Correction in accordance with Federal and State Laws which mandate the submission of a Plan of Correction as a condition for participation in the Medicare and Medicaid program. This Plan of Correction shall constitute this facility's credible allegation compliance with this section.</p> <p style="text-align: center;">RECEIVED SEP 1 2015 FACILITY STANDARDS</p>	
K 018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3.</p> <p>This Standard is not met as evidenced by: Based on observation, operational testing, and interview the facility failed to maintain doors that protect corridor openings. Failure to maintain corridor doors could allow smoke and dangerous</p>	K 018	<p>K 018</p> <p><i>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</i></p> <p>The resident room door and door frame in room 209 were adjusted. The door closes properly with no gaps between the edge of the door and the door frame.</p> <p><i>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</i></p> <p>This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567. However, all residents may have the potential to be affected by this deficiency; hence by 08/17/2015 the Administrator or designee will assess all resident room door frames to ensure they close properly with no gaps between the edge of the door and the door frame.</p>	8/17/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMINISTRATOR	(X6) DATE 8/31/15
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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 018	Continued From page 1 gases to pass freely in a fire event. This deficient practice affected 10 residents, staff, and visitors on the date of survey. The facility is licensed for 41 SNF/NF beds with a census of 37 on the day of survey. Findings include: During the facility tour on August 12, 2015 at approximately 11:30 AM, observation and operational testing of the door to room 209 revealed the door would not close properly allowing an approximately 1 inch gap between the the edge of the door and the door frame. The door was not capable of resisting the passage of smoke. When asked, the Maintenance Supervisor stated the facility was unaware of the door not closing properly. Actual NFPA standard: 18.3.6.3.1* Doors protecting corridor openings shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.	K 018	K 018 cont... <i>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</i> To ensure that the deficient practice does not recur, starting on 08/17/2015 the Administrator or designee will do weekly checks of all resident room doors and door frames to ensure they close properly with no gaps between the edge of the door and the door frame. <i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</i> Monitoring will be done through: The Administrator or designee will do visual observation to at least three (3) residents' room doors to ensure they close properly with no gaps between the edge of the door and the door frame. Monitoring will start on 08/24/2015. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3. The Administrator or designee will present to the quarterly QA&A Committee meeting the findings and/or corrective actions taken. Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.	
K 022 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4	K 022	K 022 Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: A quote was received on 8/26/2015 for installation of the access to exit signs. Access to exit signs will be scheduled to be installed at the west end of the 200 hallway corridor on 9/2/2015 so as to be visible from the east end of the 200 hallway corridor making exit access visible to any residents or staff on the 200 hall.	8/26/2015

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K 022	Continued From page 2 This Standard is not met as evidenced by: Based upon observation and interview the facility failed to ensure exit signs were visible from all areas within the facility exit access corridor system. Failure to provide exit signage could result in impeded or delayed evacuation in an emergency. This deficient practice affected 10 residents, staff and visitors on the day of the survey. The facility is licensed for 41 SNF/NF beds with a census of 37 on the day of survey. Findings include: During the facility tour on August 12, 2015 at approximately 3:00 PM, observation revealed no exit sign was clearly visible in the exit access corridor of the 200 hallway. When asked, the Maintenance supervisor stated the facility was unaware of the exit signage requirement. Actual NFPA Standard: 7.10.1.4* Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. Sign placement shall be such that no point in an exit access corridor is in excess of 100 ft (30 m) from the nearest externally illuminated sign and is not in excess of the marked rating for internally illuminated signs.	K 022	K 022 cont... <i>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</i> This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567. However, all residents may have the potential to be affected by this deficiency; hence by 08/17/2015 the Administrator or designee will assess all access to exits in the facility to ensure they are marked clearly and are visible to residents, staff and visitors. <i>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</i> To ensure that the deficient practice does not recur, starting on 08/17/2015 the Administrator or designee will do a weekly check of all access to exits signs in the facility to ensure they are marked clearly and are visible to residents, staff and visitors. <i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</i> Monitoring will be done through: The Administrator or designee will do visual observation of three (3) access to exits in the facility to ensure they are marked clearly and are visible to residents, staff and visitors. Monitoring will start on 08/24/2015. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3. The Administrator or designee will present to the quarterly QA&A Committee meeting the findings and/or corrective actions taken. Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.	
K 048 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 18.7.1.1	K 048	K 048 <i>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</i>	8/17/2015

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K 048	Continued From page 3 This Standard is not met as evidenced by: Based on interview, the facility failed to ensure a written copy of an emergency plan was readily available at all times. Failure to have an emergency plan available at all times could cause confusion and delay operations or evacuation during an emergency event. This deficient practice affected all residents, staff, and visitors on the date of the survey. The facility is licensed for 41 SNF/NF beds with a census of 37 on the day of survey. Findings Include: During the facility tour on August 12, 2015 at approximately 2:30 PM, interview with the support staff at the nurses station revealed the facility did not have a written copy of the emergency plan readily available at all times. When asked, the Administrator stated the emergency plan is located in the administrators office and is locked after hours. Actual NFPA standard: 18.7.1.1 The administration of every health care occupancy shall have, in effect and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire, for their evacuation to areas of refuge, and for their evacuation from the building when necessary. All employees shall be periodically instructed and kept informed with respect to their duties under the plan. A copy of the plan shall be readily available at all times in the telephone operator's position or at the security center.	K 048	K 048 cont... A copy of the emergency plan binder was placed where it is readily available at all times. <i>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</i> This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567. However, all residents may have the potential to be affected by this deficiency; hence: By 08/17/2015 the Administrator or designee will ensure that the emergency binder is readily available at all times. By 08/17/2015, all staff will be in-serviced by the Administrator or designee regarding K-048, with reference to the importance of the emergency plan binder being readily available at all times. <i>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</i> To ensure that the deficient practice does not recur, starting on 08/17/2015 the Administrator or designee will do daily checks to ensure that the emergency plan binder is readily available at all times. <i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</i> Monitoring will be done through: The Administrator or designee will do visual observation of the emergency plan binder to ensure it is readily available at all times. Monitoring will start on 08/24/2015. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3. The Administrator or designee will present to the quarterly QA&A Committee meeting the findings and/or corrective actions taken. Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.	
K 147	NFPA 101 LIFE SAFETY CODE STANDARD	K 147		

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K 147 SS=D	<p>Continued From page 4</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 16 residents, staff and visitors on the date of survey. The facility is licensed for 41 SNF/NF beds with a census of 37 the day of survey.</p> <p>Findings Include:</p> <p>During the facility tour on August 12, 2015 at approximately 2:00 PM, observation of the soiled linen room in the 100 hallway revealed multiple mobile soiled linen receptacles blocking the electrical breaker panels. When asked, the maintenance supervisor stated the facility was unaware of the blocked electrical panels but was aware the mobile soiled linen receptacles were stored in the room.</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>	K 147	<p>K 147</p> <p><i>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</i></p> <p>The soiled linen receptacles that were blocking access to the electrical panels in the soiled linen room have been moved to allow appropriate access.</p> <p><i>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</i></p> <p>This deficiency is an isolated deficiency as reflected in the Statement of deficiencies-form CMS-2567. However, all residents may have the potential to be affected by this deficiency; hence: By 08/17/2015 the Administrator or designee will ensure that in the soiled linen room the electrical breaker panels have the proper work space to allow access to them. By 08/17/2015, all staff will be in-serviced by the Administrator or designee regarding K-147, with reference to the importance of the electrical breaker panels having the proper work space to allow access to them.</p> <p><i>Measures that will be put into place or systemic changes you will make to ensure that the deficient practice does not recur includes the following:</i></p> <p>To ensure that the deficient practice does not recur, starting on 08/17/2015 the Administrator or designee will do daily rounds to ensure that in the soiled linen room the electrical breaker panels have the proper work space to allow access to them.</p> <p><i>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</i></p> <p>Monitoring will be done through:</p> <p>The Administrator or designee will do visual observation of the soiled linen room to ensure the electrical breaker panels have the proper work space to allow access to them.</p> <p>Monitoring will start on 08/24/2015. This will be done weekly x 4, then q 2 weeks x 4, then monthly x 3.</p> <p>The Administrator or designee will present to the quarterly QA&A Committee meeting the findings and/or corrective actions taken.</p> <p>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A Committee quarterly meeting.</p>	8/17/2015

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K 147	Continued From page 5 (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.	K-147		