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 27, 2015

Chase Gunderson, Administrator
Owyhee Health & Rehabilitation Center
PO Box A
Homedale, ID 83628-2040

Provider #: 135087

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

Dear Mr. Gunderson:

On **August 17, 2015**, a Facility Fire Safety and Construction survey was conducted at **Owyhee Health & Rehabilitation 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

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 9, 2015.** Failure to submit an acceptable PoC by **September 9, 2015**, may result in the imposition of civil monetary penalties by **September 29, 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 21, 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 21, 2015**. A change in the seriousness of the deficiencies on **September 21, 2015**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **September 21, 2015**, includes the following:

Denial of payment for new admissions effective **November 17, 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 17, 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 17, 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:

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 9, 2015**. If your request for informal dispute resolution is received after **September 9, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ENTIRE NF STRUCTURE B. WING _____	(X3) DATE SURVEY COMPLETED
	135087		08/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWYHEE HEALTH & REHABILITATION CENTE	108 WEST OWYHEE HOMEDALE, ID 83628

(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 000	INITIAL COMMENTS The facility is a single story, type V(111) construction. The latest addition was in 1990. The facility was originally built in 1959. The facility is fully sprinklered and is equipped with smoke detection in common areas and corridors. Currently the facility is licensed for 49 SNF/NF beds. The following deficiencies were cited during the annual fire/life safety survey conducted on August 17, 2015. The facility was surveyed under the LIFE SAFETY CODE 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70. The survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	K 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Owyhee Health and Rehab does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
K 064 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure fire extinguishers were installed in accordance with NFPA 10. Failure to mount fire extinguishers at the correct height could result in injury or extinguisher damage. This deficient practice affected 29 residents, staff and visitors on the date of the survey. The facility is licensed for 49 SNF/NF beds and had a census of 29 on	K 064	K 064 **Corrective Actions:** Fire extinguishers outside room 23, outside the ED office, and in the corridor outside room 1 will be moved to 5 feet to the top of the extinguisher. **Identification of others affected and corrective actions:** All fire extinguishers in the facility will be measured and the placement adjusted as needed. All residents, staff, and visitors may have been affected. **Measures to ensure that the deficient practice does not happen again:** All extinguishers will be mounted and measured by the plant manager. **Monitor corrective actions:** Plant manager and administrator will measure all fire extinguishers to ensure proper height. **Corrective Actions will be completed**	9/9/15

RECEIVED
SEP 03 2015
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Chuck Neider	Administrator	9/9/15

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 064	Continued From page 1 the day of the survey. Findings include: During the facility tour conducted on August 17, 2015 from 11:00 AM to 3:30 PM, observation of the fire extinguishers installed in the facility revealed the following deficiencies: The extinguishers located outside room 23 and the Administration office were installed at 67 inches when measured from the floor to the top of the extinguisher. The extinguisher located in the corridor outside the Business office and the corridor outside room #1 were installed at 61 inches when measured from the floor to the top of the extinguisher. When interviewed, the Maintenance Supervisor stated he had recently re-mounted the extinguishers, but did not realize the required measurement was to the top of the extinguisher, not the center of the gauge. Actual NFPA standard: 1-6.10 Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor. Fire extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be so installed that the top of the fire extinguisher is not more than 31/2 ft (1.07 m) above the floor. In no case shall the clearance between the bottom of the fire extinguisher and the floor be less than 4 in. (10.2 cm).	K 064		
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 072	K 072 **Corrective Actions:** 1) Throw bolts removed from clean linen and storage door in the kitchen. Single operational lock placed on the door to the clean linen room and storage room in the kitchen. 2) Door handle in ED office replaced with single operational lock. 3) Mirror removed from door and door was painted.	

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K 072	Continued From page 2 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, operational testing and interview, the facility failed to ensure doors provided a readily accessible means of egress. Failure to allow rapid means of egress could hinder safe evacuation during an emergency. This deficient practice affected 11 residents, staff and visitors on the date of the survey. The facility is licensed for 49 SNF/NF beds and had a census of 29 on the day of the survey. Findings include: 1) During the facility tour conducted on August 17, 2015 from 11:00 AM to 3:30 PM, observation and operational testing of doors to the clean linen room abutting room #15 and the storage door in the Kitchen revealed both were equipped with throw bolts mounted at the top of the door, approximately seventy (70) inches from the floor, prohibiting operation of the door from the egress side. 2) During the facility tour conducted on August 17, 2015 from 11:00 AM to 3:30 PM, observation and operational testing of the door to the Administration office revealed it was equipped with a non-single operational lock. 3) During the facility tour conducted on August 17,	K 072	**Identification of others affected and corrective actions:** 11 residents, staff and visitors may have been affected. Anyone trying to gain access to these rooms or exit may have also been affected. **Measures to ensure that the deficient practice does not happen again:** All facility door handles will be checked to ensure they have single operational locks on all doors with locks. All exits checked to ensure no mirrors are on the exit door. Plant manager will install all new door handles and check exit doors monthly to ensure they are clear of mirrors.	

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K 072	Continued From page 3 2015 from 11:00 AM to 3:30 PM, observation of the exit door abutting room #1 revealed it had a mirror installed on it. When asked about the installations of the throw bolts and the non-single operational lock to the Administration office, the Maintenance Supervisor stated he was not aware of the requirement for single operational locks. Actual NFPA standard: Finding 1 & 2 7.1.10 Means of Egress Reliability. 7.1.10.1* 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. 7.2.1.5.4* A latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and that is readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 in. (86 cm), and not more than 48 in. (122 cm), above the finished floor. Doors shall be operable with not more than one releasing operation. Exception No. 1*: Egress doors from individual living units and guest rooms of residential occupancies shall be permitted to be provided with devices that require not more than one additional releasing operation, provided that such device is operable from the inside without the use of a key or tool and is mounted at a height not exceeding 48 in. (122 cm) above the finished floor. Existing security devices shall be permitted to have two additional releasing operations.	K 072	**Monitor corrective actions:** Plant manager and administrator will tour facility and check all door handles and exit doors. They will make sure that all doors have single operational locks and no mirrors exist on exit doors. Plant manager will check all doors and exits quarterly. **Corrective Actions will be completed**	9/9/15

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K 072	Continued From page 4 Existing security devices other than automatic latching devices shall not be located more than 60 in. (152 cm) above the finished floor. Automatic latching devices shall not be located more than 48 in. (122 cm) above the finished floor. Exception No. 2: The minimum mounting height for the releasing mechanism shall not be applicable to existing installations. Finding 3 7.1.10.2.3 Mirrors shall not be placed on exit doors. Mirrors shall not be placed in or adjacent to any exit in such a manner as to confuse the direction of egress.	K 072		
K 144 SS=F	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 on record review and interview, the facility failed to ensure the generator (EPSS) was exercised for thirty percent of it's load capacity for thirty minutes. Failure to perform load tests for the EPSS could result in a lack of system performance during a power failure. This deficient practice affected 29 residents, staff and visitors on the date of the survey. The facility is licensed for 49 SNF/NF beds and had a census of 29 on	K 144	K 144 **Corrective Actions:** Facility will have certified electrician train plant manager on conducting a monthly load test to load requirements. Electrician will conduct monthly test during visit with plant manager. **Identification of others affected and corrective actions:** No residents affected. **Measures to ensure that the deficient practice does not happen again:** Certified electrician will train plant manager and assist with the next monthly test to ensure understanding and compliance of testing requirements. **Monitor corrective actions:** Certified electrician will train and monitor the execution of the next monthly test. **Corrective Actions will be completed**	9/18/15

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K 144	Continued From page 5 the day of the survey. Findings include: During review of provided EPSS logs conducted on August 17, 2015 from 9:30 AM to 11:00 AM, the logs revealed no load being documented for any of the thirty (30) minute load tests conducted from January 5, 2015 to August 3, 2015. When asked about the missing documentation and the method by which he conducted his monthly testing, the Maintenance Supervisor stated he ran the generator monthly for thirty minutes, but was not aware of any specific method for documenting the load achieved during these tests. Actual NFPA standard: NFPA 99 Standard for Healthcare Facilities 1999 Edition 3-4.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches. (a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-4.3.1. Maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6. (b) Inspection and Testing. 1. * Test Criteria. Generator sets shall be tested twelve (12) times a year with testing intervals between not less than 20 days or exceeding 40 days. Generator sets serving emergency and	K 144		

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K 144	Continued From page 6 equipment systems shall be in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6. 2. Test Conditions. The scheduled test under load conditions shall include a complete simulated cold start and appropriate automatic and manual transfer of all essential electrical system loads. 3. Test Personnel. The scheduled tests shall be conducted by competent personnel. The tests are needed to keep the machines ready to function and, in addition, serve to detect causes of malfunction and to train personnel in operating procedures. 3-4.4.2 Recordkeeping. A written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. NFPA 110 6-4 Operational Inspection and Testing. 6-4.2* Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (a) Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating (b) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer The date and time of day for required testing shall be decided by the owner, based on facility operations.	K 144		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance	K 147	K 147 **Corrective Actions:** 1) Exposed wiring in dry storage off the kitchen will be covered. 2) Bulb-to-outlet adapter/converter was removed and replaced with a single light bulb.	

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K 147	Continued From page 7 with NFPA 70, National Electrical Code. 9.1.2 This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure electrical installations were in accordance with NFPA 70. Failure to ensure electrical systems are installed properly could result in fire by arcing or electrocution. This deficient practice affected staff and vendors of the main Kitchen on the date of the survey. The facility is licensed for 49 SNF/NF beds and had a census of 29 on the day of the survey. Findings include: 1) During the facility tour conducted on August 17, 2015 from 11:00 AM to 3:30 PM, observation of the electrical panels located in the dry storage of the Kitchen revealed one of the panels with an approximately two inch by two inch square opening, exposing the wiring inside the shut-off panel. 2) During the facility tour conducted on August 17, 2015 from 11:00 AM to 3:30 PM, observation of the door area leading from the Kitchen past the oxygen storage revealed the outside light consisted of a bulb with a bulb-to-outlet adapter/converter with two receptacles. Further observation revealed an additional plug adapter installed into one of these outlets. When asked, the Maintenance Supervisor stated he was unaware of these installations. Actual NFPA standard: Finding 1	K 147	**Identification of others affected and corrective actions:** No residents, staff, or visitors were affected. **Measures to ensure that the deficient practice does not happen again:** All lights in the facility checked to ensure no bulb-to-outlet adapters/converters are attached. **Monitor corrective actions:** Plant manager and ED to verify that no bulb-to-outlet adapters/converters are attached. Plant manager to check monthly for three months. **Corrective Actions will be completed**	9/9/15

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K 147	Continued From page 8 NFPA 70 110.12 Mechanical Execution of Work. Electrical equipment shall be installed in a neat and workmanlike manner. (A) Unused Openings. Unused cable or raceway openings in boxes, raceways, auxiliary gutters, cabinets, cutout boxes, meter socket enclosures, equipment cases, or housings shall be effectively closed to afford protection substantially equivalent to the wall of the equipment. Where metallic plugs or plates are used with nonmetallic enclosures, they shall be recessed at least 6 mm (¼ in.) from the outer surface of the enclosure. (B) Subsurface Enclosures. Conductors shall be racked to provide ready and safe access in underground and subsurface enclosures into which persons enter for installation and maintenance. (C) Integrity of Electrical Equipment and Connections. Internal parts of electrical equipment, including busbars, wiring terminals, insulators, and other surfaces, shall not be damaged or contaminated by foreign materials such as paint, plaster, cleaners, abrasives, or corrosive residues. There shall be no damaged parts that may adversely affect safe operation or mechanical strength of the equipment such as parts that are broken; bent; cut; or deteriorated by corrosion, chemical action, or overheating. 314.17 Conductors Entering Boxes, Conduit Bodies, or Fittings. Conductors entering boxes, conduit bodies, or fittings shall be protected from abrasion and shall comply with 314.17(A) through (D). (A) Openings to Be Closed. Openings through which conductors enter shall be adequately closed.....	K 147		

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K 147	Continued From page 9 Finding 2 IDAPA 16.03.02.120 10. Electrical and Lighting. All electrical and lighting installation shall be in accordance with the National Electrical Code (1984 ed.) and as follows: c. Plug adaptors and multiple outlets are prohibited.	K 147		