



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. 'BUTCH' OTTER – Governor
RICHARD M. ARMSTRONG – Director

TAMARA PRISOCK – ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
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3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

September 16, 2015

Arthur Gulden, Administrator
Bingham Memorial Skilled Nursing & Rehabilitation
98 Poplar Street
Blackfoot, ID 83221-1758

Provider #: 135007

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

Dear Mr. Gulden:

On **September 9, 2015**, a Facility Fire Safety and Construction survey was conducted at **Bingham Memorial Skilled Nursing & 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 29, 2015**. Failure to submit an acceptable PoC by **September 29, 2015**, may result in the imposition of civil monetary penalties by **October 19, 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 **October 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 **October 14, 2015**. A change in the seriousness of the deficiencies on **October 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 **October 14, 2015**, includes the following:

Denial of payment for new admissions effective **December 9, 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 **March 9, 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 **September 9, 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 29, 2015**. If your request for informal dispute resolution is received after **September 29, 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

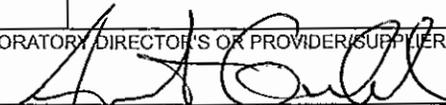
MPG/lj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135007	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE NF B. WING _____	(X3) DATE SURVEY COMPLETED 09/09/2015
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NAME OF PROVIDER OR SUPPLIER BINGHAM MEMORIAL SKILLED NURSING & R	STREET ADDRESS, CITY, STATE, ZIP CODE 98 POPLAR STREET BLACKFOOT, ID 83221
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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 (III) structure with a two hour fire wall to the JCAHO accredited hospital. The facility was originally built in 1963 with renovation and addition in 1999. The building is fully sprinklered and is licensed for 70 beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on September 9, 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>Nate Elkins Health Facility Surveyor Facility Fire Safety & Construction</p>	K 000	<p>The following Plan of Correction is submitted by the facility in accordance with the pertinent terms and provisions of 42 CFR Section 488 and/or related state regulations, and is intended to serve as a credible allegation of our intent to correct the practices identified as deficient. The Plan of Correction should not be construed or interpreted as an admission that the deficiencies alleged did, in fact, exist; rather, the facility is filing this document in order to comply with its obligations as a provider participating in the Medicare/Medicaid program(s).</p> <p style="text-align: right;">RECEIVED SEP 24 2015 FACILITY STANDARDS</p>	
K 018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p>	K 018	<p>K 018</p> <p>Corrective action for residents found to have been affected by this deficiency:</p> <p>429 door fixed so that it closes without any hindrance.</p> <p>410 door fixed so that it closes without any hindrance.</p> <p>419 door fixed so that it closes without any hindrance.</p> <p>Corrective action for residents that may be affected by this deficiency:</p> <p>All residents on the 400 ball have the potential to be affected by these identified concerns.</p> <p>3 identified doors fixed so they close without hindrance</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 9/23/15
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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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NAME OF PROVIDER OR SUPPLIER BINGHAM MEMORIAL SKILLED NURSING & R		STREET ADDRESS, CITY, STATE, ZIP CODE 98 POPLAR STREET BLACKFOOT, ID 83221		
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K 018	Continued From page 1 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 gases to pass freely between smoke compartments. This deficient practice has the potential to affect 13 residents, staff, and visitors on the date of survey. The facility is licensed for 70 SNF/NF beds with a census of 38 on the day of survey. Findings include: 1.) During the facility tour on September 9, 2015 at approximately 11:15 AM, observation and operational testing of the corridor door to room 429 revealed the door would only close half way due to the flooring impeding the progress of the door. 2.) During the facility tour on September 9, 2015 at approximately 11:20 PM, observation and operational testing of the corridor door to room 410 revealed the door would not close properly because of a loose door strike was impeding the progress of the door. When asked, the Maintenance Supervisor stated the facility was unaware of the door not closing properly 3.) During the facility tour on September 9, 2015 at approximately 11:45 pm, observation of room 419 labeled Dialysis Osmosis revealed the self closing door was blocked open by a metal bracket.	K 018	3 identified doors, rms 410, 419, and 429, will be checked 3 times a week for at least 4 weeks beginning the week of 10/5/15 to ensure continued compliance. Full facility audit completed to ensure all the other doors close properly. In-service will be given by Safety Officer to engineering staff, dialysis staff, and skilled-nursing staff before 10/14/15 regarding corridor doors closing properly and not being propped open or impeded Measures that will be put into place to ensure that this deficiency does not recur: Director of Engineering or Administrator will complete an audit of at least 5 corridor doors each weekly for at least 12 weeks beginning the week of 10/5/15. Any issues will be reported to the Safety Committee. Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur: The Safety Committee will review any issues uncovered by weekly audits and after the initial 12 weeks make a determination related to changing the frequency of those audits. Additionally, Safety Committee will review facility progress on firewall penetrations on an on-going basis to aid in monitoring compliance.	10/14/15

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K 018	<p>Continued From page 2</p> <p>When asked, the Maintenance Supervisor stated they were unaware of the impediments of the doors.</p> <p>Actual NFPA standard:</p> <p>19.3.6.3 Corridor Doors. 19.3.6.3.1*</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and 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.</p> <p>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.</p> <p>Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.</p>	K 018		
K 062 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p>	K 062	<p><u>K 062</u></p> <p>Corrective action for residents found to have been affected by this deficiency:</p> <p>Sprinkler system antifreeze solution percentage tested and documented for the sprinkler system prior to 10/14/15.</p>	

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K 062	<p>Continued From page 3</p> <p>This Standard is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that the fire suppression system was tested and maintained in accordance with NFPA 25. Failure to provide proper testing and inspection of sprinkler systems could result in these systems not performing as designed during a fire event. This deficient practice affected all residents, staff and visitors on the date of the survey. The facility is licensed for 70 SNF/NF beds and had a census of 38 on the day of the survey.</p> <p>Findings Include:</p> <p>During record review on September 9, 2015 at approximately 10:00 AM, the facility was unable to provide documentation for antifreeze solution percentage in the automatic sprinkler system. Upon further investigation of the sprinkler riser room revealed no percentage was documented on any monthly or annual tags. When asked, the maintenance supervisor stated they were unaware the antifreeze percentage was required to be tested and documented.</p> <p>Actual NFPA standards:</p> <p>NFPA 25, 2-3.4* Antifreeze Systems. The freezing point of solutions in antifreeze shall be tested annually by measuring the specific gravity with a hydrometer or refractometer and adjusting the solutions if necessary. Solutions shall be in accordance with Tables 2-3.4(a) and (b). The use of antifreeze solutions shall be in accordance with any state or local health regulations. [See Table 2-3.4(b).]</p>	K 062	<p>Corrective action for residents that may be affected by this deficiency:</p> <p>All residents have the potential to be affected by these identified concerns.</p> <p>Sprinkler system antifreeze solution percentage tested and documented for the sprinkler system prior to 10/14/15.</p> <p>In-service will be provided by Administrator and Safety Officer to engineering department regarding the need sprinkler system antifreeze solution percentage testing.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>Administrator and/or Safety Officer will check and document monthly for at least 12 months that the facility is up to date on Sprinkler System testing</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>The Safety Committee will review any issues uncovered by monthly checks and after the initial 12 months will make a determination related to changing the frequency of those audits.</p>	10/14/15	