



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

October 14, 2015

Darwin Royeca, Administrator
Lincoln County Care Center
PO Box 830
Shoshone, ID 83352-1502

Provider #: 135056

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

Dear Mr. Royeca:

On **October 5, 2015**, a Facility Fire Safety and Construction survey was conducted at **Lincoln County 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 **October 27, 2015**. Failure to submit an acceptable PoC by **October 27, 2015**, may result in the imposition of civil monetary penalties by **November 16, 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 **November 9, 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 **November 9, 2015**. A change in the seriousness of the deficiencies on **November 9, 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 **November 9, 2015**, includes the following:

Denial of payment for new admissions effective **January 5, 2016**.
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 **April 5, 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 **October 5, 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:

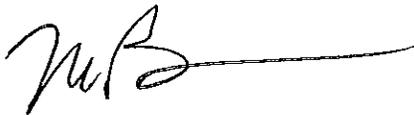
BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **October 27, 2015**. If your request for informal dispute resolution is received after **October 27, 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

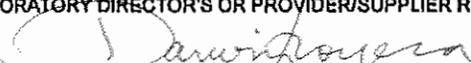
Revised: 10/14/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135058	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/05/2015
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NAME OF PROVIDER OR SUPPLIER LINCOLN COUNTY CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 511 EAST 4TH STREET SHOSHONE, ID 83352
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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 built in 1958. It is fully sprinklered building with smoke detection coverage throughout the facility. There is a partial basement that contains the boiler room, storage, and employee lounge. Currently the facility is licensed for 36 beds.</p> <p>The following deficiencies were cited during the annual Fire/Life Safety survey conducted on October 5, 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 style="text-align: right;">RECEIVED OCT 13 2015 STATE OF IDAHO</p>	
K 012 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure the fire and smoke resistive integrity of the building. Failure to ensure the smoke and fire resistive properties of the facility could allow smoke and dangerous gases to pass freely and add to the rapid development of fire in exposed wall cavities. This deficient practice affected staff and visitors on the date of the survey. The facility is licensed for 36 SNF/NF</p>	K 012	<p>K012</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>The facility will ensure to maintain the fire and smoke resistive integrity of the building.</p> <p>Maintenance director have sealed the 2 inches in diameter hole cut through the interior of the wall by a fire retardant foam sealant on October 7, 2015.</p>	10/23/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Administrator</i>	(X6) DATE 10/23/15
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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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135056	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/05/2015
NAME OF PROVIDER OR SUPPLIER LINCOLN COUNTY CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 511 EAST 4TH STREET SHOSHONE, ID 83352		
(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 012	<p>Continued From page 1 beds with a census of 28 on the day of the survey.</p> <p>Findings include:</p> <p>1.) During the facility tour on October 5, 2015 between 1:00 PM and 4:30 PM, observation of the Central Supply room near the nurse station found an approximately 2 inch diameter hole cut through the interior of the wall. When asked, the Maintenance Supervisor and the Administrator stated the facility was unaware of the hole in the wall.</p> <p>2.) During the facility tour on October 5, 2015 between 1:00 PM and 4:30 PM, observation of the Boiler Room in the basement found an approximate 3 inch diameter hole and two 2 inch diameter holes cut through the interior of the wall exposing the boiler room to the stairwell. When asked, the Maintenance Supervisor and the Administrator stated the facility was unaware of the hole in the wall.</p> <p>Actual NFPA standard:</p> <p>19.1.6.2 Health care occupancies shall be limited to the types of building construction shown in Table 19.1.6.2. (See 8.2.1.) Exception*: Any building of Type I(443), Type I(332), Type II(222), or Type II(111) construction shall be permitted to include roofing systems involving combustible supports, decking, or roofing, provided that the following criteria are met: (a) The roof covering meets Class C requirements in accordance with NFPA 256, Standard Methods of Fire Tests of Roof Coverings.</p>	K 012	<p>Maintenance director have sealed the 3 inches in diameter hole and the 2 inches in diameter holes cut through the interior of the wall in the boiler or water heater room with a fire retardant foam sealant.</p> <p>All residents, visitors and staff have the potential to be affected by this practice.</p> <p>Staff were in serviced on Life Safety Code Citation and deficient practice. All staff that will notice holes should notify Maintenance director or administrator.</p> <p>Maintenance supervisor will inspect any vendor services or contractors work upon completion to ensure the smoke and fire integrity of the building is maintain and all holes and wall and ceiling penetration are sealed with fire retardant caulking or sealant.</p> <p>Please see Exhibit.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135056	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/06/2015
NAME OF PROVIDER OR SUPPLIER LINCOLN COUNTY CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 511 EAST 4TH STREET SHOSHONE, ID 83362		
(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 012	Continued From page 2 (b) The roof is separated from all occupied portions of the building by a noncombustible floor assembly that includes not less than 2 1/2 in. (6.4 cm) of concrete or gypsum fill. (c) The attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system. 8.2.1* Construction. Buildings or structures occupied or used in accordance with the individual occupancy chapters (Chapters 12 through 42) shall meet the minimum construction requirements of those chapters. NFPA 220, Standard on Types of Building Construction, shall be used to determine the requirements for the construction classification. Where the building or facility includes additions or connected structures of different construction types, the rating and classification of the structure shall be based on either of the following: (1) Separate buildings if a 2-hour or greater vertically-aligned fire barrier wall in accordance with NFPA 221, Standard for Fire Walls and Fire Barrier Walls, exists between the portions of the building Exception: The requirement of 8.2.1(1) shall not apply to previously approved separations between buildings. (2) The least fire-resistive type of construction of the connected portions, if no such separation is provided.	K 012	Maintenance Director will complete one audit weekly to ensure that pyxis room/Central Supply hole and boiler room/water heater holes stay sealed and intact. Administrator will sign the completed weekly inspection and Audit. Audits and inspections will start on October 14, 2015. All audits will be reviewed at monthly CQI meeting.	
K 022 SS=F	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	K022 NFPA 101 LIFE SAFETY CODE STANDARD The facility will ensure that access to exits were clearly identified with exit signs.	10/28/15

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135066	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/05/2015
NAME OF PROVIDER OR SUPPLIER LINCOLN COUNTY CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 511 EAST 4TH STREET SHOSHONE, ID 83352		
(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 022	<p>Continued From page 3</p> <p>This Standard Is not met as evidenced by: Based on observation and interview, the facility failed to ensure that access to exits were clearly identified with exit signs. Failure to ensure that exits are identified clearly would hinder egress during an emergency. This deficient practice could potentially affect all residents, staff and visitors on the date of the survey. The facility is licensed for 36 SNF/NF beds with a census of 28 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour on October 5, 2015 between 1:00 PM and 4:30 PM, observation revealed no exit sign was in place at the doors leading from the dining room area towards the south corridor exit access. When asked, the Maintenance Supervisor and the Administrator stated the facility was unaware of the required exit sign.</p> <p>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.</p>	K 022	<p>On October 22, 2015 the vendor or service provider Freedom Electric installed the exit sign above the smoke door.</p> <p>All residents, visitors and staff have the potential to be affected by this practice.</p> <p>Staff were In serviced on Life Safety Code Citation and deficient practice and the exit plan alternative. Maintenance director will assure that all required exit signs are in place and all sign are visible and working properly.</p> <p>Please see Exhibit.</p> <p>Maintenance Director will complete a weekly Exit sign inspection and audit to ensure that all required exit signs are in place and all sign are visible and working properly. Administrator will sign the completed weekly inspection and Audit.</p> <p>Audits and Inspections will start on October 14, 2015.</p> <p>All audits will be reviewed at monthly CQI meeting.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135056	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/05/2015
NAME OF PROVIDER OR SUPPLIER LINCOLN COUNTY CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 511 EAST 4TH STREET SHOSHONE, ID 83352		
(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 022	Continued From page 4 Exception: Signs in exit access corridors in existing buildings shall not be required to meet the placement distance requirements.	K 022		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 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 affecting egress and protection in place during a fire event. This deficient practice affected all residents staff and visitors on the date of the survey. The facility is licensed for 36 SNF/NF beds with a census of 28 on the day of the survey. Findings include: 1.) During the facility tour on October 5, 2015 between 1:00 PM and 4:30 PM, observation of room 18 in the west wing revealed an approximate 3 inch hole in the ceiling near the smoke detector that would not resist the passage of smoke.	K 025	K025 NFPA 101 LIFE SAFETY CODE STANDARD The facility will ensure that smoke barriers are maintained. Maintenance director have sealed the approximately 3 inches hole by the smoke detector in Room# 3, 6 and 18 with a fire retardant foam sealant on October 7, 2015. All residents, visitors and staff have the potential to be affected by this practice. Staff were in serviced on Life Safety Code Citation and deficient practice. All staff noticing hole/holes ceiling in room should notify maintenance director or administrator.	10/23/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135056	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/05/2015
NAME OF PROVIDER OR SUPPLIER LINCOLN COUNTY CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 611 EAST 4TH STREET SHOSHONE, ID 83352		
(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 025	<p>Continued From page 5</p> <p>2.) During the facility tour on October 5, 2015 between 1:00 PM and 4:30 PM, observation of room 3 in the east wing revealed an approximate 3 inch hole in the ceiling near the smoke detector that would not resist the passage of smoke.</p> <p>3.) During the facility tour on October 5, 2015 between 1:00 PM and 4:30 PM, observation of room 9 in the east wing revealed an approximate 3 inch hole in the ceiling near the smoke detector that would not resist the passage of smoke.</p> <p>When asked, the Maintenance Supervisor and the Administrator stated the facility was aware of the penetrations near the smoke detectors.</p> <p>Actual NFPA standard:</p> <p>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</p>	K 025	<p>Maintenance director will inspect any vendor services or contractors work upon completion to ensure the smoke and fire integrity of the building is maintain and all holes and wall and ceiling penetration are sealed with fire retardant caulking or sealant.</p> <p>Please see Exhibit.</p> <p>Maintenance Director will complete inspection and audit weekly to ensure a that ceiling hole in Room #3, 9 and 18 stay sealed and intact. Administrator will sign the completed weekly inspection and Audit.</p> <p>Audits and Inspections will start on October 14, 2015.</p> <p>All audits will be reviewed at monthly CQI meeting.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 136066	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/05/2015
NAME OF PROVIDER OR SUPPLIER LINCOLN COUNTY CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 511 EAST 4TH STREET SHOSHONE, ID 83362		
(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 025	Continued From page 6 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.	K 025		
K 064 SS=D	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 that fire extinguishers were installed in accordance with NFPA 10. Failure to ensure fire extinguishers were installed at the correct height and unobstructed could inhibit their use during a fire event. This deficient practice affected staff and visitors on the date of the survey. The facility is licensed for 36 SNF/NF beds with a census of 28 on the day of the survey. Findings include: 1.) During the facility tour on October 5, 2015 between 1:00 PM and 4:30 PM, observation	K 064	K064 NFPA 101 LIFE SAFETY CODE STANDARD The facility will ensure that all fire extinguishers are installed in accordance to NFPA 10 and are installed at a correct height and unobstructed On October 12, 2015 the Maintenance director removed the current fire extinguisher and installed a smaller or 5 lbs fire extinguisher by the nurse's station in compliance with the maximum height requirement of 60 inches.	10/23/15

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

Revised: 10/14/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135066	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/06/2015
NAME OF PROVIDER OR SUPPLIER LINCOLN COUNTY CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 511 EAST 4TH STREET SHOSHONE, ID 83362		
(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 064	<p>Continued From page 7</p> <p>revealed the ABC fire extinguishers located near the nurse station/telephone room was installed above the maximum height requirement of 60 inches. The height measured was approximately 67 inches above the floor.</p> <p>2.) During the facility tour on October 5, 2015 between 1:00 PM and 4:30 PM, observation revealed the ABC fire extinguishers located in the Therapy room office was installed above the maximum height requirement of 60 inches. The height measured was approximately 70 inches above the floor.</p> <p>3.) During the facility tour on October 5, 2015 between 1:00 PM and 4:30 PM, observation of the kitchen revealed access to the "K" style fire extinguisher was blocked by an ice machine.</p> <p>When asked, Maintenance Supervisor and the Administrator stated the facility was unaware of the extinguisher height requirements and the blocked extinguisher.</p> <p>Actual NFPA standard: NFPA 10 Standard for Portable Fire Extinguishers Item #1-2 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 3 1/2 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).</p>	K 064	<p>On October 7, 2015 the Maintenance director removed and re installed fire extinguisher in the activity office or therapy room in compliance with the maximum height requirement of 60 inches.</p> <p>On October 7, 2015 the Maintenance director removed and re installed K type fire extinguisher in the kitchen in a different location and is now not block by any equipment.</p> <p>All residents, visitors and staff have the potential to be affected by this practice.</p> <p>Staff were in serviced on Life Safety Code Citation and deficient practice. All staff will assure that the fire extinguisher is not block by any equipment and is always readily accessible.</p> <p>Please see Exhibit.</p> <p>Maintenance Director will complete a weekly Fire Extinguisher height inspection and to ensure that fire extinguisher is not block by any equipment. Administrator will sign the completed weekly inspection and Audit.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 138066	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/05/2015
NAME OF PROVIDER OR SUPPLIER LINCOLN COUNTY CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 511 EAST 4TH STREET SHOSHONE, ID 83352		
(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 064	Continued From page 8 Item #3 1-6.6* Fire extinguishers shall not be obstructed or obscured from view. Exception: In large rooms, and in certain locations where visual obstruction cannot be completely avoided, means shall be provided to indicate the location.	K 064	Audits and Inspections will start on October 14, 2015. All audits will be reviewed at monthly CQI meeting.	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance 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 wiring was in accordance with the National Electrical Code. The deficient practice affected staff, and visitors on the date of survey. The facility is licensed for 36 SNF/NF beds with a census of 28 on the day of survey. Findings include: During the facility tour on October 5, 2015 between between 1:00 PM and 4:30 PM, observation of the Therapy room revealed an air conditioning unit plugged into a relocatable power tap which was being used as fixed wiring. When asked, the Maintenance Supervisor and the Administrator stated the facility was unaware the air conditioning unit was plugged into a relocatable power tap. Actual NFPA standard: NFPA 70 National Electrical Code 1999 Edition Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the	K 147	K 147 NFPA 101 LIFE SAFETY CODE STANDARD The facility will ensure that electrical wiring is in accordance with National Electrical Code and not use a relocatable power tap for air conditioning unit. On October 7, 2015 the Maintenance director removed the Air Conditioning Unit in the therapy room. All residents, visitors and staff have the potential to be affected by this practice. Staff were in serviced on Life Safety Code Citation and deficient practice. All staff will assure that air conditioning unit will not be plugged in a relocatable power tap.	10/23/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135056	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 10/05/2015
NAME OF PROVIDER OR SUPPLIER LINCOLN COUNTY CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 511 EAST 4TH STREET SHOSHONE, ID 83352		
(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 147	Continued From page 9 following: 1. As a substitute for the fixed wiring of a structure 2. Where run through holes in walls, structural ceilings suspended ceilings, dropped ceilings, or floors 3. Where run through doorways, windows, or similar openings 4. Where attached to building surfaces Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-8. 5. Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors 6. Where installed in raceways, except as otherwise permitted in this Code See UL listings: XBYS Guide Information XBZN2 Guide Information	K 147	Please see Exhibit. Maintenance Director will complete a weekly relocatable power tap inspection to ensure that air conditioning units are not plugged in to a relocatable power tap. Administrator will sign the completed weekly inspection and Audit. Audits and Inspections will start on October 14, 2015. All audits will be reviewed at monthly CQI meeting.	