



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

November 27, 2015

Joshua Bowman, Administrator  
Teton Post Acute Care & Rehabilitation  
3111 Channing Way  
Idaho Falls, ID 83404-7534

Provider #: 135138

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

Dear Mr. Bowman:

On **November 18, 2015**, a Facility Fire Safety and Construction survey was conducted at **Teton Post Acute Care & 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 one that comprises a pattern that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when

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you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **December 10, 2015**. Failure to submit an acceptable PoC by **December 10, 2015**, may result in the imposition of civil monetary penalties by **December 30, 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 **December 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 **December 23, 2015**. A change in the seriousness of the deficiencies on **December 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 **December 23, 2015**, includes the following:

Denial of payment for new admissions effective **February 18, 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 **May 18, 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 **November 18, 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 **December 10, 2015**. If your request for informal dispute resolution is received after **December 10, 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. Grines, Supervisor  
Facility Fire Safety and Construction

MPG/lj  
Enclosures

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

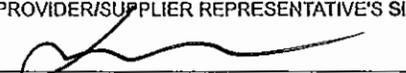
PRINTED: 11/27/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135138	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - TETON POST ACUTE CARE & REHABILITATION  B. WING _____	(X3) DATE SURVEY COMPLETED  11/18/2015
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NAME OF PROVIDER OR SUPPLIER  TETON POST ACUTE CARE & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHANNING WAY IDAHO FALLS, ID 83404
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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) building with pitched roof and composite shingles. The building is approximately 43,000 square feet, and is composed of a service wing, a center core, and four resident wings. The building was originally built in 1988, but was unoccupied and re-licensed in May of 2013 for 88 skilled nursing beds. The facility is fully sprinklered with a dry system covering the attic and a wet system with quick response heads covering the resident care areas. The building has a manual fire alarm system with corridor smoke detection interconnected with the sprinkler flow switches, the system is off site monitored. The building is served by a natural gas powered generator, automatic transfer switches and two branch circuits. There are multiple exits to grade equipped with delayed egress devices.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on November 18, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Chapter 18 New Health Care Occupancy in accordance with 42 CFR 483.70</p> <p>The Survey was conducted by: Nate Elkins Health Facility Surveyor Facility Fire Safety &amp; Construction</p> <p>K 018 SS=E 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>	K 000	<p>DEC - 9 2015</p> <p>K018 FACILITY STANDARDS</p> <ul style="list-style-type: none"> <li>How corrective action accomplished for the identified residents? On 11/19/2015 the sequencing on the door between the med rec room and the corridor was adjusted/repared so it would properly close and latch.</li> <li>How you will identify other residents with the potential of being affected by the same practice? All residents have the potential to be effected. Other hazardous areas have had the doors observed to validate they are sequencing and closing correctly on or before 12/14/2015.</li> <li>Address what measures will be put in place to ensure deficient practice will not recur. Maintenance staff will be re-educated by the Administrator regarding fire doors requiring sequencing to ensure that they are functioning appropriately to allow for doors to close and latch.</li> </ul>	12/14/15
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Executive Director	(X6) DATE 12/8/2015
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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	<p>Continued From page 1</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 gases to pass freely between smoke compartments. This deficient practice affected 20 residents, staff, and visitors on the date of survey. The facility is licensed for 88 SNF/NF beds with a census of 38 on the day of survey.</p> <p>Findings include:</p> <p>During the facility tour on November 18, 2015 at approximately 11:30 AM, observation and operational testing of the Med Rec Room in the 200 hallway revealed the door would not close properly. When observed, the door with the astragal would close first not allowing the doors to seal properly leaving an approximate 2 inch clearance between the doors.</p> <p>When asked, the Maintenance Supervisor and the Administrator stated the facility was unaware the door did not close properly.</p> <p>Actual NFPA standard:</p> <p>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</p>	K 018	<ul style="list-style-type: none"> <li><i>How will the plan be monitored to ensure the solutions are sustained?</i> The Maintenance Director or designee will audit fire doors to validate the doors are sequencing appropriately and securely latching. These audits will be completed: 1 day a week X4 weeks, and 1 day a month continually.</li> <li>Findings will be brought to CQI monthly for further review and educational opportunities.</li> <li><i>Compliance date is 12/14/2015</i></li> </ul>		

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K 018	Continued From page 2 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 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  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that exits were clearly identified by appropriate means. Failure to ensure exits are identified clearly would hinder the safe evacuation of occupants during an emergency. This deficient practice affected 18 residents, staff and visitors on the date of the survey. The facility is licensed for 88 SNF/NF beds with a census of 38 on the day of the survey.  Findings include:  During the facility tour on November 18, 2015 at approximately 10:30 AM observation of the exit sign in the 200 hallway found the exit sign directional to the right and left indicated by an arrow or chevron and would lead occupants into the lounge and a storage room.	K 022	<i>K022</i> • <i>How corrective action(s) accomplished for the identified residents?</i> On 12/4/2015 the exit sign in the 200 hallway was replaced/corrected according to the surveyor's suggestion and to comply with life safety regulation and guidelines.	12/4/15

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K 022	Continued From page 3  When asked, the Maintenance Supervisor stated the facility was unaware of the arrows or chevrons were wrong on the exit signs.  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. Exception: Signs in exit access corridors in existing buildings shall not be required to meet the placement distance requirements.  7.10.2* Directional Signs. A sign complying with 7.10.3 with a directional indicator showing the direction of travel shall be placed in every location where the direction of travel to reach the nearest exit is not apparent.	K 022	<ul style="list-style-type: none"> <li>• <i>How you will identify other residents with the potential of being affected by the same practice?</i> All residents have the potential to be affected. All of the exit signs throughout the facility were inspected to validate that they have appropriate arrow directions on 12/4/2015. No other misleading arrows were observed/found.</li> <li>• <i>Address what measures will be put in place to ensure deficient practice will not recur.</i> The Maintenance Director will be re-educated by the Administrator regarding appropriate arrow directions on facility exit signs.</li> </ul>	
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1  This STANDARD is not met as evidenced by: Based on observation, operational testing and	K 029	<ul style="list-style-type: none"> <li>• <i>How will the plan be monitored to ensure the solutions are sustained?</i> The Maintenance Director or designee will audit exit signs quarterly to ensure accurate arrow directions on all exit signs. These audits will be completed: Once each quarter continuously.</li> <li>• <i>Compliance date is 12/4/2015</i></li> </ul>	

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K 029	<p>Continued From page 4</p> <p>interview, the facility failed to ensure that hazardous areas were protected with self-closing doors. Failure to provide self-closing doors for hazardous areas would allow smoke and dangerous gases to pass freely into corridors and hinder egress of occupants during a fire event. This deficient practice affected 7 residents, staff and visitors on the date of the survey. The facility is licensed for 88 SNF/NF beds and had a census of 38 on the day of the survey.</p> <p>Findings include:</p> <p>1.) During the facility tour on November 18, 2015 at approximately 10:00 AM, observation and operational testing of the clean linen storage room in the 400 hallway revealed the self closing door would not close and latch properly. When asked, the Maintenance Supervisor and the Administrator stated the facility was unaware the door would not self-close properly.</p> <p>2.) During the facility tour on November 18, 2015 at approximately 2:00 PM, observation and operational testing of the wheel chair storage room in the 100 hallway revealed the door would not be on a self-closure/ The room was measured to be greater than 100 square feet that stored combustible material. When asked, the Maintenance Supervisor and the Administrator stated the facility was unaware the door was required to be on a self closure.</p> <p>Actual NFPA standard:</p> <p>18.3.2.1* Hazardous Areas. Any hazardous area shall be protected in accordance with Section 8.4. The areas described in Table 18.3.2.1 shall be</p>	K 029	<p><i>K029</i></p> <ul style="list-style-type: none"> <li><i>How corrective action(s) accomplished for the identified residents?</i> <u>Finding 1</u> On 12/5/2015 the self-closer on the clean linen room in the 400 hallway was replaced with new self-closing unit and does latch appropriately. <u>Finding 2</u> Self-closer was added to the wheelchair storage room in the 100 hallway and does latch appropriately.</li> <li><i>How you will identify other residents with the potential of being affected by the same practice?</i> <u>Finding 1</u> All residents have the potential to be affected. On 12/5/2015, All hazardous areas were inspected to verify that self-closing doors latch properly. <u>Finding 2</u> All residents have the potential to be affected. On 12/5/2015, All hazardous areas were inspected to verify that self-closing doors latch properly. Mattress storage room in 100 hallway was identified as a potential hazardous area and a self-closer was put on the door. The door does close and latch appropriately.</li> </ul>	12/5/15

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K 029	Continued From page 5 protected as indicated.	K 029		
K 076 SS=D	<p>8.4.1.3 Doors in barriers required to have a fire resistance rating shall have a 3/4-hour fire protection rating and shall be self-closing or automatic-closing in accordance with 7.2.1.8. NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 18.3.2.4</p> <p>This STANDARD is not met as evidenced by: Based upon observation and interview the facility failed to ensure oxygen cylinders were secured and stored in a safe manner. Failure to secure and maintain cylinders can result in physical damage to the cylinder and could create an oxygen enriched atmosphere. This deficient practice affected staff and visitors on the day of survey. The facility is licensed for 88 SNF/NF beds with a census of 38 on the date of survey.</p> <p>Findings include:</p> <p>During the facility tour on November 18, 2015 at approximately 9:30 AM, observation of the</p>	K 076	<ul style="list-style-type: none"> <li>Address what measures will be put in place to ensure deficient practice will not recur. <u>Finding 1</u> The Maintenance Director will be re-educated by the Administrator regarding requirements of self-closing doors to latch appropriately. <u>Finding 2</u> The Maintenance Director will be re-educated by the Administrator regarding requirements for all hazardous areas to have functioning self-closing doors that latch appropriately.</li> <li>How will the plan be monitored to ensure the solutions are sustained? <u>Finding 1</u> The Maintenance Director or designee will audit self-closing doors to verify that they latch appropriately. These audits will be completed: 1 X week for 1 month, then 1X month continually. Findings will be brought to CQI monthly for further review and educational opportunities.</li> </ul>	

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K 076	<p>Continued From page 6</p> <p>oxygen transfilling room in the 300 hallway revealed 7 unsecured "E" style oxygen tanks that were not properly secured in a cylinder stand or cart. When asked, the Maintenance Supervisor stated he was unaware of the freestanding gas cylinders.</p> <p>Actual NFPA standard: NFPA 99</p> <p>4-3.1.1.2 Storage Requirements (Location, Construction, Arrangement). (a)* Nonflammable Gases (Any Quantity; In-Storage, Connected, or Both)</p> <p>1. Sources of heat in storage locations shall be protected or located so that cylinders or compressed gases shall not be heated to the activation point of integral safety devices. In no case shall the temperature of the cylinders exceed 130°F (54°C). Care shall be exercised when handling cylinders that have been exposed to freezing temperatures or containers that contain cryogenic liquids to prevent injury to the skin.</p> <p>2.* Enclosures shall be provided for supply systems cylinder storage or manifold locations for oxidizing agents such as oxygen and nitrous oxide. Such enclosures shall be constructed of an assembly of building materials with a fire-resistive rating of at least 1 hour and shall not communicate directly with anesthetizing locations. Other nonflammable (inert) medical gases may be stored in the enclosure. Flammable gases shall not be stored with oxidizing agents. Storage of full or empty cylinders is permitted. Such enclosures shall serve no other purpose.</p> <p>3. Provisions shall be made for racks or fastenings to protect cylinders from accidental</p>	K 076	<p><u><b>Finding 2</b></u></p> <p>The Maintenance Director or designee will audit hazardous areas to ensure they have self-closers on the doors that latch appropriately. These audits will be completed: 1 X week for 1 month, then 1X month continually.</p> <p>Findings will be brought to CQI monthly for further review and educational opportunities.</p> <ul style="list-style-type: none"> <li>• <i>Compliance date is 12/5/2015</i></li> </ul>	

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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 076	<p>Continued From page 7 damage or dislocation.</p> <p>4. The electric installation in storage locations or manifold enclosures for nonflammable medical gases shall comply with the standards of NFPA 70, National Electrical Code, for ordinary locations. Electric wall fixtures, switches, and receptacles shall be installed in fixed locations not less than 152 cm (5 ft) above the floor as a precaution against their physical damage.</p> <p>5. Storage locations for oxygen and nitrous oxide shall be kept free of flammable materials [see also 4-3.1.1.2(a)7].</p> <p>6. Cylinders containing compressed gases and containers for volatile liquids shall be kept away from radiators, steam piping, and like sources of heat.</p> <p>7. Combustible materials, such as paper, cardboard, plastics, and fabrics, shall not be stored or kept near supply system cylinders or manifolds containing oxygen or nitrous oxide. Racks for cylinder storage shall be permitted to be of wooden construction. Wrappers shall be removed prior to storage. Exception: Shipping crates or storage cartons for cylinders.</p> <p>8. When cylinder valve protection caps are supplied, they shall be secured tightly in place unless the cylinder is connected for use.</p> <p>9. Containers shall not be stored in a tightly closed space such as a closet [see 8-2.1.2.3(c)].</p> <p>10. Location of Supply Systems. a. Except as permitted by 4-3.1.1.2(a)10c, supply systems for medical gases or mixtures of these gases having total capacities (connected and in storage) not exceeding the quantities specified in 4-3.1.1.2(b)1 and 2 shall be located outdoors in an enclosure used only for this purpose or in a room or enclosure used only for this purpose situated within a building used for other purposes.</p>	K 076	<p><i>K076</i></p> <ul style="list-style-type: none"> <li><i>How corrective action(s) accomplished for the identified residents?</i> On 12/4/2015 all unnecessary e-cylinder tanks were returned to O2 vendors. The remaining tanks were secured in tank racks.</li> <li><i>How you will identify other residents with the potential of being affected by the same practice?</i> All residents have the potential to be affected. Remaining e-cylinder tanks were secured in holding racks on 12/4/2015.</li> <li><i>Address what measures will be put in place to ensure deficient practice will not recur.</i> The Maintenance Director and all staff will be educated regarding appropriate storage of e-cylinder tanks.</li> </ul>	12/14/15
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135138	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - TETON POST ACUTE CARE & REHABILITATION  B. WING _____	(X3) DATE SURVEY COMPLETED  11/18/2015
NAME OF PROVIDER OR SUPPLIER  TETON POST ACUTE CARE & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHANNING WAY IDAHO FALLS, ID 83404	
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K 076	<p>Continued From page 8</p> <p>b. Storage facilities that are outside, but adjacent to a building wall, shall be in accordance with NFPA 50, Standard for Bulk Oxygen Systems at Consumer Sites.</p> <p>c. Locations for supply systems shall not be used for storage purposes other than for containers of nonflammable gases. Storage of full or empty containers shall be permitted. Other nonflammable medical gas supply systems or storage locations shall be permitted to be in the same location with oxygen or nitrous oxide or both. However, care shall be taken to provide adequate ventilation to dissipate such other gases in order to prevent the development of oxygen-deficient atmospheres in the event of functioning of cylinder or manifold pressure-relief devices.</p> <p>d. Air compressors and vacuum pumps shall be located separately from cylinder patient gas systems or cylinder storage enclosures. Air compressors shall be installed in a designated mechanical equipment area, adequately ventilated and with required services.</p> <p>11. Construction and Arrangement of Supply System Locations.</p> <p>a. Walls, floors, ceilings, roofs, doors, interior finish, shelves, racks, and supports of and in the locations cited in 4-3.1.1.2(a)10a shall be constructed of noncombustible or limited-combustible materials.</p> <p>b. Locations for supply systems for oxygen, nitrous oxide, or mixtures of these gases shall not communicate with anesthetizing locations or storage locations for flammable anesthetizing agents.</p> <p>c. Enclosures for supply systems shall be provided with doors or gates that can be locked.</p> <p>d. Ordinary electrical wall fixtures in supply rooms shall be installed in fixed locations not less than 5</p>	K 076	<ul style="list-style-type: none"> <li>• <i>How will the plan be monitored to ensure the solutions are sustained?</i> The Maintenance Director or designee will audit oxygen storage room to ensure tanks are secured and stored appropriately. These audits will be completed: Once each week for 4 weeks, then once each month for 3 months. Findings will be brought to CQI monthly for further review and educational opportunities.</li> <li>• <i>Compliance date is 12/14/2015</i></li> </ul>

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K 076	<p>Continued From page 9</p> <p>ft (1.5 m) above the floor to avoid physical damage.</p> <p>e. Where enclosures (interior or exterior) for supply systems are located near sources of heat, such as furnaces, incinerators, or boiler rooms, they shall be of construction that protects cylinders from reaching temperatures exceeding 130°F (54°C). Open electrical conductors and transformers shall not be located in close proximity to enclosures. Such enclosures shall not be located adjacent to storage tanks for flammable or combustible liquids.</p> <p>f. Smoking shall be prohibited in supply system enclosures.</p> <p>g. Heating shall be by steam, hot water, or other indirect means. Cylinder temperatures shall not exceed 130°F (54°C).</p> <p>(b) Additional Storage Requirements for Nonflammable Gases Greater Than 3000 ft<sup>3</sup> (85 m<sup>3</sup>).</p> <p>1. Oxygen supply systems or storage locations having a total capacity of more than 20,000 ft<sup>3</sup> (566 m<sup>3</sup>) (NTP), including unconnected reserves on hand at the site, shall comply with NFPA 50, Standard for Bulk Oxygen Systems at Consumer Sites.</p> <p>2. Nitrous oxide supply systems or storage locations having a total capacity of 3200 lb (1452 kg) [28,000 ft<sup>3</sup> (793 m<sup>3</sup>) (NTP)] or more, including unconnected reserves on hand at the site, shall comply with CGA Pamphlet G-8.1, Standard for the Installation of Nitrous Oxide Systems at Consumer Sites.</p> <p>3. The walls, floors, and ceilings of locations for supply systems of more than 3000 ft<sup>3</sup> (85 m<sup>3</sup>) total capacity (connected and in storage) separating the supply system location from other occupancies in a building shall have a fire resistance rating of at least 1 hour. This shall also</p>	K 076	

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K 076	Continued From page 10 apply to a common wall or walls of a supply system location attached to a building having other occupancy. 4. Locations for supply systems of more than 3000 ft3 (85 m3) total capacity (connected and in storage) shall be vented to the outside by a dedicated mechanical ventilation system or by natural venting. If natural venting is used, the vent opening or openings shall be a minimum of 72 in.2 (0.05 m2) in total free area. (c) Storage Requirements for Nonflammable Gases Less Than 3000 ft3 (85 m3). Doors to such locations shall be provided with louvered openings having a minimum of 72 in.2 (0.05 m2) in total free area. Where the location of the supply system door opens onto an exit access corridor, louvered openings shall not be used, and the requirements of 4-3.1.1.2(b)3 and 4 and the dedicated mechanical ventilation system required in 4-3.1.1.2(b)4 shall be complied with.	K 076	K143  • <i>How corrective action(s) accomplished for the identified residents?</i> On 12/3/2015 the fan motor of the mechanical ventilation system was replaced in the oxygen transfilling room in the 300 hallway.	12/14/15
K 143 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Transferring of oxygen is:  (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;  (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and  (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2	K 143	• <i>How you will identify other residents with the potential of being affected by the same practice?</i> All residents have the potential to be affected. Ventilation fan was replaced in the only oxygen transfilling and storage room.  • <i>Address what measures will be put in place to ensure deficient practice will not recur.</i> The Maintenance Director will be educated regarding the requirement to ensure the ventilation system in the oxygen room is operational and continually operating.	

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K 143	<p>Continued From page 11</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide a safe environment for the transfilling of oxygen from one container to another. Failure to provide a safe environment for transfilling of oxygen could create an oxygen-enriched atmosphere within the vicinity of the containers. This deficient practice affected staff and visitors on the day of survey. The facility is licensed for 88 SNF/NF beds with a census of 38 on the date of survey.</p> <p>Findings include:</p> <p>During the facility tour on November 18, 2015 at approximately 9:30 AM, observation of the oxygen transfilling room in the 300 hallway revealed the mechanical ventilation system was not operational or continuously operating. The room was observed to be the oxygen transfilling room as well as an oxygen cylinder storage room. When asked, the Maintenance Supervisor stated the facility was unaware of the the mechanical ventilation system was not operational and stated the system should operate continuously. This finding was acknowledged by the Maintenance Supervisor and the Administrator at the exit conference.</p> <p>Actual NFPA standard:</p> <p>NFPA 99</p> <p>8-6.2.5.2 Transferring Liquid Oxygen. Transferring of liquid oxygen from one container to another shall be accomplished at a location</p>	K 143	<ul style="list-style-type: none"> <li>How will the plan be monitored to ensure the solutions are sustained?</li> </ul> <p>The Maintenance Director or designee will audit oxygen storage room to ensure mechanical ventilation system is operational and continuously operating. These audits will be completed: Once each month continuously.</p> <ul style="list-style-type: none"> <li>Compliance date is 12/14/2015</li> </ul>	

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K 143 Continued From page 12  
specifically designated for the transferring that is as follows:  
(a) Separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and  
(b) The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring; and  
(c) The area is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted.  
Transferring shall be accomplished utilizing equipment designed to comply with the performance requirements and producers of CGA Pamphlet P-2.6, Transfilling of Low-Pressure Liquid Oxygen to be Used for Respiration, and adhering to those procedures.  
The use and operation of small portable liquid oxygen systems shall comply with the requirements of CGA Pamphlet P-2.7, Guide for the Safe Storage, Handling and Use of Portable Liquid Oxygen Systems in Health Care Facilities.

K 143