



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK – ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Eder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

January 22, 2016

Briar Heisler, Administrator
Life Care Center of Idaho Falls
2725 East 17th Street
Idaho Falls, ID 83406-6601

Provider #: 135091

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Ms. Heisler:

On **January 12, 2016**, a Facility Fire Safety and Construction survey was conducted at **Life Care Center of Idaho Falls** 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 **February 4, 2016**. Failure to submit an acceptable PoC by **February 4, 2016**, may result in the imposition of civil monetary penalties by **February 24, 2016**.

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 **February 16, 2016**, (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 **February 16, 2016**. A change in the seriousness of the deficiencies on **February 16, 2016**, 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 **February 16, 2016**, includes the following:

Denial of payment for new admissions effective **April 12, 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 **July 12, 2016**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Mark P. Grimes, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on **January 12, 2016**, 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 **February 4, 2016**. If your request for informal dispute resolution is received after **February 4, 2016**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,



Mark P. Grimes, Supervisor
Facility Fire Safety and Construction

MPG/lj
Enclosures

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

PRINTED: 01/20/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135091	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 01/12/2016
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF IDAHO FALLS	STREET ADDRESS, CITY, STATE, ZIP CODE 2725 EAST 17TH STREET IDAHO FALLS, ID 83406
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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	INITIAL COMMENTS The facility is a single story Type V (III) building with partial basement housing hot water heaters. The fully sprinklered structure was built in 1978. A new smoke detection system was installed in 2011. A major renovation was completed in 1998. Currently it is licensed for 109 NF beds. The following deficiency was cited at the above facility during the Fire/Life Safety survey conducted on January 12, 2016. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy and 42 CFR 483.70. The Survey was conducted by: Nate Elkins Health Facility Surveyor Fire Life Safety & Construction	K 000	<i>This Plan of Correction is submitted as required under Federal and State regulations and statutes applicable to long-term care providers. The Plan of Correction does not constitute an admission of liability on part of the facility, and such liability is specifically denied. The submission of this Plan of Correction does not constitute agreement by the facility that the surveyors findings and/or conclusions constitute a deficiency, or that the scope and severity of the deficiencies cited are correctly applied.</i>	
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD 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 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance	K 018	SPECIFIC ISSUE 1. Cross corridor doors in hallway #3 that revealed a gap between the facing edge of the doors when closed were adjusted appropriately to close the gap. 2. Hallway #4 the door leading to room 61 with a 3/4 inch gap on the top corner was adjusted to sealed properly. 3. Cross Corridor doors in hallway #4 with the clearance between the bottom of the door and the floor covering was adjusted properly to close the gap to less than 1 inch per the requirement.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ED	(X6) DATE 1/28/16
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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.

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

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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF IDAHO FALLS			STREET ADDRESS, CITY, STATE, ZIP CODE 2725 EAST 17TH STREET IDAHO FALLS, ID 83406	
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K 018	<p>Continued From page 1</p> <p>with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3</p> <p>This STANDARD is not met as evidenced by: Based on observation, operational testing, and interview the facility failed to maintain doors that protect corridor openings. Failure to maintain corridor doors would allow the passage of smoke and dangerous gases to travel freely and negate the opportunity to defend in place. This deficient practice affected 30 residents, staff and visitors in 3 of 6 smoke compartments on the date of the survey. The facility is licensed for 109 SNF/NF beds with a census of 61 on the day of the survey.</p> <p>Findings include:</p> <p>1.) During the facility tour on January 12, 2016 at approximately 11:30 AM, observation and operational testing of the cross corridor doors in hallway #3 revealed an approximate 1/2 inch to 3/4 inch gap between the facing edge of the doors when closed completely that would allow the passage of smoke. When asked, the Maintenance Supervisor stated the facility was unaware of the gap between the doors.</p> <p>2.) During the facility tour on January 12, 2016 at approximately 2:45 PM, observation and operational testing of the door leading to room 61 in hallway #4 revealed the door would not close and seal properly leaving an approximate 3/4 inch gap between the top corner of the door and door frame that would allow the passage of smoke. When asked, the Maintenance Supervisor stated the facility was unaware the door would not seal properly.</p>	K 018	<p>OTHER AREAS</p> <p>All corridor doors were inspected in the facility to identify any other doors that have excessive gaps. Any doors identified were repaired and adjusted as needed to ensure compliance.</p> <p>SYSTEMIC CHANGES</p> <p>Maintenance Director will schedule routine checks on corridor doors for gaps to be completed every two weeks for two months then monthly thereafter. Any gaps identified on the routine checks will be remedied as needed to assure compliance.</p> <p>MONITOR</p> <p>The Maintenance Director will inspect monthly 2 corridor doors to monitor the system. Maintenance Director will bring results of the monitor inspection along with a copy of the routine checks completed by Maint. Staff to the QAPI meeting monthly for review.</p>	02/16/2016

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K 018	Continued From page 2 3.) During the facility tour on January 12, 2016 at approximately 3:00 PM, observation and operational testing of the cross corridor doors in hallway #4 revealed an approximate 1-1/2 inch clearance between bottom of door and floor covering exceeding the 1 inch requirement when closed. When asked, the Maintenance Supervisor stated the facility was unaware of the gap between the door and the floor. Actual NFPA standard: 19.3.6.3 Corridor Doors. 19.3.6.3.1* 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. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. 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.	K 018		
K 025	NFPA 101 LIFE SAFETY CODE STANDARD	K 025		

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K 025 SS=D	Continued From page 3 Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 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. This deficient practice affected 18 residents, staff and visitors on the date of survey. The facility is licensed for 109 SNF/NF beds with a census of 61 on the day of the survey. Findings include: During the facility tour on January 12, 2016 at approximately 11:00 AM, observation of the ceiling in room #20 revealed a 3 inch circular hole cut into the ceiling near the sprinkler head that was unsealed. When asked, the Maintenance Supervisor stated the facility was unaware of the hole in the ceiling. Actual NFPA standard: 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	K 025	K 025 SPECIFIC The 3 inch circular hole in room #20 was sealed as appropriate. OTHER Inspection of the facility ceilings was completed and any other area where a smoke barrier was compromise as identified in the inspection was sealed as appropriate. SYSTEMIC CHANGES Maintenance Director will add a routine schedule of inspection of ceilings. Maintenance staff will inspect every two weeks for two months then monthly thereafter per the routine schedule ceilings to ensure smoke barriers are maintained as appropriate.	

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K 025	Continued From page 4 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. 8.3.2* Continuity. Smoke barriers required by this Code shall be 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	MONITOR Maintenance Director to inspect one hallway per month the ceilings for any holes to monitor the effectiveness of the system. Maintenance Director will bring the results of the monitor along with the schedule of the routine checks to the monthly QAPI meeting for review.	02/16/2016
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with 0 hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed	K 029		

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K 029	<p>Continued From page 5</p> <p>48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure hazardous areas were protected with doors that would resist the passage of smoke. Failure to provide doors in 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 residents, staff and visitors utilizing the main dining room on the date of the survey. The facility is licensed for 109 SNF/NF beds with a census of 61 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour on January 12, 2016 at approximately 1:30 PM, observation and operational testing of the doors leading from the dining room into the kitchen found when closed revealed a 1" gap between the door and the door frame. Upon further investigation it was revealed the doors would not close and seal properly leaving a 3" gap between the leading edge of both doors when closed. When asked, the Maintenance Supervisor stated the facility was unaware of the gaps between the doors and did not close properly.</p> <p>Actual NFPA standard:</p> <p>3.3.13.2 Area, Hazardous. An area of a structure or building that poses a degree of hazard greater than that normal to the general occupancy of the building or structure, such as areas used for the storage or use of combustibles or flammables; toxic, noxious, or</p>	K 029	<p>K029</p> <p>SPECIFIC</p> <p>The kitchen doors leading from the dining room into the kitchen were adjusted appropriately to close the gap per requirement</p> <p>OTHER</p> <p>Other hazardous areas of the facility were inspected to assure that the doors when closed did not have excessive gaps. Any areas identified were corrected to ensure compliance</p> <p>SYSTEM</p> <p>Maintenance Director will add a routine schedule of inspection of doors in hazardous areas. Maintenance staff will inspected every two weeks for two months then monthly thereafter per the routine schedule of doors in hazardous areas to ensure they seal properly,</p>	

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K 029	Continued From page 6 corrosive materials; or heat-producing appliances. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard.	K 029	MONITOR Maintenance Director to inspect one hazardous area door per month for gaps to monitor the effectiveness of the system. Maintenance Director will bring the results of the monitor along with the schedule of the routine checks to monthly QAPI meeting for review.	02/16/2016
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10.	K 064		

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K 064	<p>Continued From page 7 18.3.5.6, 19.3.5.6 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 correctly could inhibit their proper use during a fire event. This deficient practice affected staff on the date of the survey. The facility is licensed for 109 SNF/NF beds with a census of 61 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour on January 12, 2016 at approximately 1:30 PM, observation of the placard located above the "K" style fire extinguisher located in the kitchen revealed the placard was not properly marked with the correct wording. The sign stated "Secondary Backup Extinguisher". When asked, the Maintenance Supervisor stated the sign was changed prior to the survey date.</p> <p>Actual NFPA Standard: 19.3.5.6 Portable fire extinguishers shall be provided in all health care occupancies in accordance with 9.7.4.1.</p> <p>9.7.4.1* Where required by the provisions of another section of this Code, portable fire extinguishers shall be installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers.</p> <p>NFPA 10 2-3.2.1</p>	K 064	<p>K 064 SPECIFIC The "K" style fire extinguisher located in the kitchen was properly marked with the correct wording on a placard.</p> <p>OTHER Extinguishers in the facility were inspected to assure they are properly marked.</p> <p>SYSTEMIC CHANGES Maintenance staff inserviced on the appropriate wording on the placards near the fire extinguishers. Maintenance staff will check monthly the extinguishers to assure the placards are appropriately labeled.</p> <p>MONITOR Maintenance Director will inspect 5 extinguishers monthly to monitor the system and report findings to the QAPI committee monthly.</p>	02/16/2016

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K 064	Continued From page 8 A placard shall be conspicuously placed near the extinguisher that states that the fire protection system shall be activated prior to using the fire extinguisher.	K 064		
K 074 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations are flame resistant in accordance with NFPA 701 except for shower curtains. Sprinklers in areas where cubical curtains are installed shall be in accordance with NFPA 13 to avoid obstruction of the sprinkler. 10.3.1, 18.3.5.5, 19.3.5.5, 18.7.5.1, 19.7.5.1, NFPA 13 o Newly introduced upholstered furniture shall meet the char length and heat release criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3, 18.7.5.2, 19.7.5.2. o Newly introduced mattresses shall meet the char length and heat release criteria specified when tested in accordance with the method cited in 10.3.2 (3) and 10.3.4. 18.7.5.3, 19.7.5.3 o Newly introduced upholstered furniture and mattresses means purchased since March, 2003. This STANDARD is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure drapes and curtains were provided in accordance with NFPA 701. Failure to install curtains and drapes with flame resistive properties would increase the available fuel during a fire event. This deficient practice affected all residents, staff and visitors on the date of the survey. The facility is licensed	K 074	K 074 SPECIFIC The curtains and drapes identified without a tag for 701 rating were treated with fire resistant application. OTHER All curtains and drapes were inspected throughout the facility to identify any that were not tagged for 701 rating. Any curtains or drapes identified were treated with a fire resistant application. SYSTEMIC Maintenance staff inserviced on the need to inspect curtains prior to installation ensuring they are tagged for a 701 rating or have been treated with a fire resistant application. MONITOR Maintenance Director monthly will audit 10% of the rooms in the facility to ensure that the drapes or curtains are either tagged for a 701 rating or have	

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135091	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 01/12/2016
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF IDAHO FALLS			STREET ADDRESS, CITY, STATE, ZIP CODE 2725 EAST 17TH STREET IDAHO FALLS, ID 83406	
(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 074	<p>Continued From page 9 for 109 SNF/NF beds with a census of 61 on the day of the survey.</p> <p>Findings include:</p> <p>During record review on January 16, 2016 between 9:00 AM to 10:30 AM, review of the facility records failed to show any fire treatment records for non-tagged curtains or drapes. Upon further observation during the facility tour between 11:00 AM and 3:30 PM, physical inspection of curtains and drapes installed throughout the facility were not tagged for 701 rating or treated with a fire resistant application. When asked, the Maintenance Supervisor stated the facility was not aware of the non-tagged draperies and curtains.</p> <p>Actual NFPA standard:</p> <p>19.7.5.1* Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies shall be in accordance with the provisions of 10.3.1. (See 19.3.5.5.) Exception: Curtains at showers.</p> <p>10.3.1* Where required by the applicable provisions of this Code, draperies, curtains, and other similar loosely hanging furnishings and decorations shall be flame resistant as demonstrated by testing in accordance with NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films.</p>	K 074	<p>documented treatment with a fire resistant application. Audits will be reviewed monthly in the QAPI committee meeting to monitor the system.</p>	02/16/2016