



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TAMARA PRISOCK—ADMINISTRATOR
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
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January 26, 2016

Renae Oswald, Administrator
Eastern Idaho Regional Medical Center-- TCU
PO Box 2077
Idaho Falls, ID 83403-2077

Provider #: 135115

Dear Ms. Oswald:

On **January 22, 2016**, a survey was conducted at Eastern Idaho Regional Medical Center-- TCU by the Idaho Department of Health and Welfare, Division of Licensing and Certification, 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. Your facility was found to be in substantial compliance with federal health care requirements regulations during this survey.

However, your facility still has a deficiency that requires submission of a Plan of Correction. A State Form listing licensure health deficiencies is enclosed. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed.

NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3.) Please provide **ONLY ONE completion date for each state tag in column (X5) Completion Date** to signify when you allege that each tag will be back in compliance. Waiver renewals may be requested on the Plan of Correction.

Your Plan of Correction (POC) for the deficiencies must be submitted by **February 8, 2016**.

The components of a Plan of Correction, as required by CMS must:

- Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- Address how you will identify other residents who have the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- Address what measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur;
- Indicate how the facility plans to monitor performance to ensure the corrective action(s) are effective and compliance is sustained.
- Include dates when corrective action will be completed in column (X5).

If the facility has not been given an opportunity to correct, the facility must determine the date compliance will be achieved. If CMS has issued a letter giving notice of intent to implement a denial of payment for new Medicare/Medicaid admissions, consider the effective date of the remedy when determining your target date for achieving compliance.

- The administrator must sign and date the first page of the state licensure survey report, State Form.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact David Scott, R.N. or Nina Sanderson, L.S.W., Supervisors, Long Term Care at (208) 334-6626, option 2.

Sincerely,



Nina Sanderson, LSW, Supervisor
Long Term Care

NS/lj

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

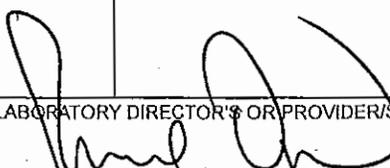
PRINTED: 01/26/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135115	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/22/2016
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NAME OF PROVIDER OR SUPPLIER EASTERN IDAHO REGIONAL MEDICAL CENTER - TCU	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 CHANNING WAY, 83404-7533 IDAHO FALLS, ID 83403
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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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F 000	<p>INITIAL COMMENTS</p> <p>A federal recertification and state licensure survey was conducted at the Eastern Idaho Regional Medical Center-TCU from January 19 to January 21, 2015 and is in substantial compliance with 42 CFR Part 483 Requirements for Long Term Care Facilities..</p> <p>The surveyors conducting the survey were: Linda Hukill-Neil, RN, Team Coordinator Kathleen Walsh, M.Ed., LCSW</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE NHA	(X8) DATE 1-30-16
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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.

Bureau of Facility Standards

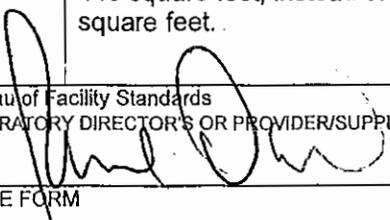
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001180	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/22/2016
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NAME OF PROVIDER OR SUPPLIER
EASTERN IDAHO REGIONAL MEDICAL CENTE

STREET ADDRESS, CITY, STATE, ZIP CODE
**3100 CHANNING WAY, 83404-7533
IDAHO FALLS, ID 83403**

(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) COMPLETE DATE
C 519	<p>02.121,06,a Resident Dining & Recreation</p> <p>06. Patient/Resident Dining and Recreation Areas. The following minimum requirements apply to dining/recreation areas.</p> <p>a. Area requirement. The total area set aside for these purposes shall be at least thirty (30) square feet per bed with a minimum, total area of at least two hundred twenty-five (225) square feet. For facilities with more than one hundred (100) beds, the minimum area may be reduced to twenty five (25) square feet per bed. If day care programs are offered, additional space shall be provided as needed to accommodate for day care patients/residents needing naps or for dining and activities. This Rule is not met as evidenced by: Based on observation, review of a previous room size waiver, and staff interview, it was determined the facility did not ensure the TCU (Transitional Care Unit) dining/recreation room complied with state regulation, the dining room must contain 30 square feet per bed. This was true for 7 of 7 (#s 1-7) sampled residents and had the potential for residents to not participate in recreational activities or eat in the dining room should the dining/recreation room become too crowded. Findings include:</p> <p>During the initial tour of the facility on 1/19/16 at 1:15 PM, it was observed the dining/recreation room in the TCU did not meet the minimum requirements. Specifically, the area measured 443 square feet, instead of the required 480 square feet.</p>	C 519	<p>We are requesting a waiver of the square footage requirement as set by the Bureau of Facility Standards for our facility's dining room. It is my understanding that according to these standards, our dining room is thirty-seven (37) square feet smaller than required. Upon recent observation by surveyors this was not found to compromise the residents' dining experience.</p>	1/25/16

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE
NHA

(X6) DATE
1-30-16

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001180	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/22/2016
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NAME OF PROVIDER OR SUPPLIER EASTERN IDAHO REGIONAL MEDICAL CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 CHANNING WAY, 83404-7533 IDAHO FALLS, ID 83403
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C 519	<p>Continued From page 1</p> <p>During the survey process, no residents were observed dining in the dining/recreation area.</p> <p>On 1/19/16 at 1:45 PM, the Administrator was asked if the facility would continue to request a waiver of the dining/recreation room size. The Administrator stated the facility wanted the waiver to be in effect again.</p> <p>The surveyors found the decreased space did not compromise residents' dining/recreation experience. The request for a waiver renewal for this requirement should be included in the facility's Plan of Correction.</p>	C 519		