



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

July 29, 2016

Bonnie Sorensen, Administrator
Countryside Care & Rehabilitation
1224 8th St
Rupert, ID 83350

Provider #: 135064

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

Dear Ms. Sorensen:

On **July 20, 2016**, a Facility Fire Safety and Construction survey was conducted at **Countryside 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 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 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

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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 **August 15, 2016**. Failure to submit an acceptable PoC by **August 15, 2016**, may result in the imposition of civil monetary penalties by **August 31, 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. If a State Form was issued as well, it should also be signed, dated and returned.

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 **August 24, 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 **August 24, 2016**. A change in the seriousness of the deficiencies on **August 24, 2016**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **August 24, 2016**, includes the following:

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Denial of payment for new admissions effective October 20, 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 January 20, 2017, 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 July 20, 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:

<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

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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 **August 15, 2016**. If your request for informal dispute resolution is received after **August 15, 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, option 3.

Sincerely,



Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures

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

Printed: 07/26/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135064	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 07/20/2016
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NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE CARE & REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 1224 EIGHTH STREET RUPERT, ID 83350
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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 main Extended Care Facility is a single story, type V(111) construction, with a two hour wall at the 1960 original hospital building. The short term (west unit) portion of the nursing facility occupies a wing of the Hospital building and is separated by a smoke barrier from the remaining hospital building which is type I construction. The entire facility is fully sprinklered with corridor smoke detection and manual fire alarm system. The facility is licensed for 46 SNF beds. The following deficiencies were cited during the annual Life Safety Code Survey conducted on July 20, 2016. The facility was surveyed under the 2000 Life Safety Code, Existing Health Care Occupancies in accordance with 42 CFR 483.70(a). The survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety & Construction	K 000	<p>RECEIVED AUG 10 2016 FACILITY STANDARDS</p>	
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD 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 smoke barriers were continuous and door assemblies would self-close and resist the passage of smoke. Failure to maintain the continuity of smoke barriers would allow smoke	K 025		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Bonnie Sorenson</i>	TITLE <i>Administrator</i>	(X6) DATE <i>8-8-16</i>
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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 025	<p>Continued From page 1</p> <p>and dangerous gases to pass between compartments hindering the ability to defend in place. This deficient practice affected 26 residents, staff and visitors on the date of the survey. The facility is licensed for 46 SNF/NF beds and had a census of 42 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on July 20, 2016 from approximately 9:30 AM to 3:30 PM, observation of the smoke barrier wall separating the dining room from the 300 north and 300 south wings revealed a door entering that wing nurse's station, was not equipped to self close. Further observation revealed the nurse's station was open directly onto the main corridor by a pass-through window. When asked about the lack of continuity in the smoke barrier wall, the Facilities Director stated he had not noticed this condition prior to the date of the survey.</p> <p>Actual NFPA standard:</p> <p>19.3.7.5 Openings in smoke barriers shall be protected by fire-rated glazing; by wired glass panels and steel frames; by substantial doors, such as 13/4-in. (4.4-cm) thick, solid-bonded wood core doors; or by construction that resists fire for not less than 20 minutes. Nonrated factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door shall be permitted. Exception: Doors shall be permitted to have fixed fire window assemblies in accordance with 8.2.3.2.2. 19.3.7.6* Doors in smoke barriers shall comply with 8.3.4</p>	K 025	<p>K-025</p> <p>Corrective Action: The identified areas:</p> <ul style="list-style-type: none"> Smoke barrier wall separating the dining room from the 300 north and 300 south wings revealed a door entering that wing nurse's station was not equipped to self close. Nurse's station was open directly onto the main corridor by a pass-through window. <p>Maintenance Supervisor is aware of the NFPA 101 standard.</p> <p>Systemic changes – Door in nurse's station will be taken out of use. A self-close door will be maintained to the door that goes into the office with the pass-through window.</p> <p>Monitor - Administrator, Maintenance Supervisor, or designee, will weekly monitor door closures for 2 weeks until 100% achieved, then monitor monthly for 3 months to assure 100% compliance is maintained.</p> <p>Quality Assurance – Administrator, Maintenance Supervisor, or designee, will report monitors to the facility's Safety Committee quarterly, beginning October 2016.</p>	<p>8/15/15 8/15/16 SB</p>

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K 025	Continued From page 2 and shall be self-closing or automatic-closing in accordance with 19.2.2.2.6. Such doors in smoke barriers shall not be required to swing with egress travel. Positive latching hardware shall not be required.	K 025		
K 064 SS=F	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. 18.3.5.6, 19.3.5.6 This Standard is not met as evidenced by: Based on record review, observation and interview, the facility failed to have annual maintenance for portable fire extinguishers in accordance with NFPA 10. Lack of annual maintenance for portable fire extinguishers could limit the early detection of equipment problems, hindering the performance of extinguishers during a fire event. This deficient practice affected 42 residents, staff and visitors on the date of the survey. The facility is licensed for 46 SNF/NF residents and had a census of 42 on the day of the survey. Findings include: During review of facility extinguisher inspection records conducted on July 20, 2016 from approximately 8:30 AM to 10:00 AM, no record was available for the annual fire extinguisher maintenance. Further observation of tags attached to each installed portable fire extinguisher revealed the last maintenance of extinguishers was March, 2015. When asked, the Facilities Director stated he was not sure why the annual inspection was missed. Actual NFPA standard:	K 064	K 064 Corrective Action: The identified areas: 1. Facility failed to have annual maintenance for portable fire extinguishers. Maintenance Supervisor is aware of the NFPA 101 standard. Systemic changes – All portable fire extinguishers were maintained on 7/29/16. Planned routine fire extinguisher maintenance will be planned annually. Monitor – Nursing Home Administrator, Maintenance Supervisor or designee, will do a facility walk through at least annually to monitor for annual maintenance of portable fire extinguishers. Quality Assurance - Maintenance Supervisor, of designee will report to the facility's Safety Committee annually, beginning August 2016.	8/15/16 8/15/16 8/15/16

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K 064	Continued From page 3 NFPA 10 4-4* Maintenance. 4-4.1 Frequency. Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 year, at the time of hydrostatic test, or when specifically indicated by an inspection.	K 064		