



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

August 30, 2016

Shon Shuldberg, Administrator
Ashton Memorial Living Center
PO Box 838
Ashton, ID 83420

Provider #: 135097

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

Dear Mr. Shuldberg:

On **August 18, 2016**, a Facility Fire Safety and Construction survey was conducted at **Ashton Memorial Living Center** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when 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 **September 12, 2016**. Failure to submit an acceptable PoC by **September 12, 2016**, may result in the imposition of civil monetary penalties by **October 1, 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 **September 22, 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 **September 22, 2016**. A change in the seriousness of the deficiencies on **September 22, 2016**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **September 22, 2016**, includes the following:

Denial of payment for new admissions effective **November 18, 2016**. 42 CFR §488.417(a)

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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 **February 18, 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 **August 18, 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>

Go to the middle of the page to Information Letters section and click on State and select the following:

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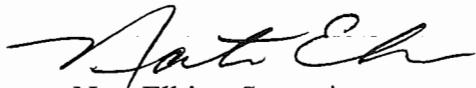
BFS Letters (06/30/11)

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

This request must be received by **September 12, 2016**. If your request for informal dispute resolution is received after **September 12, 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: 08/24/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135097	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 08/18/2016
NAME OF PROVIDER OR SUPPLIER ASHTON MEMORIAL LIVING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 700 NORTH SECOND STREET ASHTON, ID 83420		
(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 000	INITIAL COMMENTS The facility is a single story, Type V(111) construction. The building was completed April 4, 2002 and is fully sprinklered with Quick Response heads. There is smoke detection coverage throughout which includes sleeping rooms, corridors and opens spaces to corridors. There is a propane powered generator for emergency power. Currently the Living Center is licensed for 38 SNF/NF beds. The following deficiencies were cited during the annual Fire/Life Safety survey conducted on August 18, 2016. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy and in accordance with 42 CFR, 483.70. The Survey was conducted by: Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	K 000	Preparation and/or execution of the plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. <i>RECEIVED SEP 12 2016 FACILITY STANDARDS</i>	
K 029 SS=D	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 48 inches from the bottom of the door are permitted. 19.3.2.1 This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure hazardous area doors would self-close and latch. Failure to	K 029	Specific Residents - No Specific residents were identified. Other Residents - All Residents have to ability to be affected. Rm # 108 and Rm # 120 were adjusted to make sure they closed and latched. All other doors were tested and all found to latch on their own. Systemic Changes - Maintenance Director and or Environmental Supervisor will do quarterly tests on doors to make sure they self close and latch.	Sept 21, 2016

LABORATORY/DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Sh. Shilden

Administrator

9/9/16

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 029	<p>Continued From page 1</p> <p>maintain hazardous area doors could allow smoke and by-products of combustion to enter corridors during a fire, hindering egress. This deficient practice affected 10 residents, staff and visitors on the date of the survey. The facility is licensed for 38 SNF/NF beds and had a census of 30 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on August 18, 2016 from approximately 11:00 AM to 1:00 PM, observation and operational testing of door 108 which entered the copy room from the corridor, revealed the door was designed to self-close upon the activation of the fire alarm, but failed to close and latch when activated. Further observation of this space revealed the area was approximately eight feet by sixteen feet (128 sf), housing stacked boxes of paper products and office supplies.</p> <p>When asked, the Maintenance Engineer stated he was not aware this door was not completely closing as designed.</p> <p>2) During the facility tour conducted on August 18, 2016 from approximately 11:00 AM to 1:00 PM, observation and operational testing of door 120 which entered the soiled linen room from the corridor, revealed the door would not self-close and latch when activated.</p> <p>Actual NFPA standard:</p> <p>NFPA 101 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,</p>	K 029	<p>Monitor - Environmental Supervisor and or Maintenance Supervisor will report any doors not self closing & latching immediately and repairs will be scheduled. Doors needing maintenance will be tracked in QAPI committee for follow up.</p>	

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K 029	Continued From page 2 such as areas used for the storage or use of combustibles or flammables; toxic, noxious, or corrosive materials; or heat-producing appliances. 19.3.2 Protection from Hazards. 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 ft ² (9.3 m ²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft ² (4.6 m ²), 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. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 067	NFPA 101 LIFE SAFETY CODE STANDARD	K 067		

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K 067 SS=F	<p>Continued From page 3</p> <p>Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>This Standard is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure installed fire dampers were tested in accordance with NFPA 90A. Failure to maintain fire dampers could result in smoke and fire communicating through ductwork, allowing fires to grow unhindered. This deficient practice affected 30 residents, staff and visitors in 2 of 3 smoke compartments on the date of the survey. The facility is licensed for 38 SNF/NF beds and had a census of 30 on the day of the survey.</p> <p>Findings include:</p> <p>1) During review of the facility inspection records conducted on August 18, 2016 from approximately 9:00 AM to 10:00 AM, no documentation was provided for the testing of fire dampers installed in the facility.</p> <p>2) During the facility tour conducted on August 18, 2016 from approximately 10:00 AM to 1:00 PM, above the ceiling inspections by rooms 11 and 12 in the southwest corridor, revealed four (4) fire dampers were installed in the smoke barrier wall. When asked, the Maintenance Engineer stated he was not aware of any testing having been done on these dampers prior to the survey.</p> <p>Actual NFPA standard:</p> <p>NFPA 90A 3-4.7 Maintenance.</p>	K 067	<p>Specific Residents - No Specific residents were identified.</p> <p>Other Residents - All Residents have to ability to be affected. Redi Services will inspect all dampers in the facility verifying that they function properly.</p> <p>Systemic Changes - All Dampers in building were identified and will be inspected by Redi. Maintenance Director will make sure all fire dampers in building are put on a regular testing schedule at a minimum of every 4 years.</p> <p>Monitor - Inspection will be scheduled with Redi services for regular inspections of the fire dampers.</p>	Sept 21, 2016

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K 067	Continued From page 4 At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary.	K 067		
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This Standard is not met as evidenced by: Based on record review and interview, the facility failed to maintain the wet chemical fire suppression system for the Kitchen hood in accordance with NFPA 17A. Failure to maintain Kitchen hood suppression systems could result in a lack of system performance, allowing fires to grow beyond incipient stages. This deficient practice affected staff and vendors in the main Kitchen on the date of the survey. The facility is licensed for 38 SNF/NF beds and had a census of 30 on the day of the survey. Findings include: During review of inspection records provided for the Kitchen hood wet chemical suppression system conducted on August 18, 2016 from approximately 9:00 AM to 10:00 AM, records revealed the wet chemical suppression system tank was dated 2002 and was past due for its 12-year hydro testing. Interview of the Maintenance Engineer revealed he had not been aware of the deficiency noted by the vendor on the inspection reports. Actual NFPA standard: NFPA 96 10.2 Types of Equipment. 10.2.6 Automatic fire-extinguishing systems shall	K 069		

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K 069	Continued From page 5 be installed in accordance with the terms of their listing, the manufacturer 's instructions, and the following standards where applicable. (1) NFPA 12, Standard on Carbon Dioxide Extinguishing Systems (2) NFPA 13, Standard for the Installation of Sprinkler Systems (3) NFPA 17, Standard for Dry Chemical Extinguishing Systems (4) NFPA 17A, Standard for Wet Chemical Extinguishing System NFPA 17A Chapter 5 Inspection, Maintenance, and Recharging 5-5* Hydrostatic Testing. The following parts of wet chemical extinguishing systems shall be subjected to a hydrostatic pressure test at intervals not exceeding 12 years: (a) Wet chemical containers (b) Auxilliary pressure containers (c) Hose assemblies Exception No. 1: Auxiliary pressure containers not exceeding 2-in. (0.05-m) outside diameter and less than 2 ft (0.6 m) in length. Exception No. 2: Auxilliary pressure containers bearing the DOT " 3E " marking.	K 069	Specific Residents - No Specific residents were identified. Other Residents - All Residents have to ability to be affected. Simplex Grinnell has been scheduled to come and replace our 1.5 Gallon Piranha system Tank, LT-30-R Nitro Cartridge, PRX Suppression Chemical in the kitchen to new. Systemic Changes - Maintenance Director will make sure inspections of hydro static system are done every 12yrs. Monitor - Simplex Grinnells inspections will be monitored and reviewed for accuracy and deficiencies by administrator and maintenance director.	Sept 21, 2016