



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 29, 2016

Patrick Ross, Administrator  
Eastern Idaho Regional Medical Center--TCU  
PO Box 2077  
Idaho Falls, ID 83403

Provider #: 135115

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

Dear Mr. Ross:

On **August 19, 2016**, a Facility Fire Safety and Construction survey was conducted at **Eastern Idaho Regional Medical Center - TCU** 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 an isolated 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 should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces

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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 23, 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 23, 2016**. A change in the seriousness of the deficiencies on **September 23, 2016**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **September 23, 2016**, includes the following:

- Denial of payment for new admissions effective **November 19, 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 19, 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 19, 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

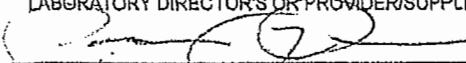
NE/lj  
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135115	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE NF FLOOR  B. WING _____	(X3) DATE SURVEY COMPLETED  08/19/2016
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NAME OF PROVIDER OR SUPPLIER EASTERN IDAHO REGIONAL MEDICAL CENTER	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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K 000	INITIAL COMMENTS  This facility is a Type II (221) construction, multi-story structure. The TCU is located on the sixth floor. Fire protection features include a complete automatic fire extinguishing system throughout installed in accordance with NFPA 13; and complete fire alarm/smoke detection system. Currently the facility is licensed for 16 SNF beds.  The facility was found to be in substantial compliance during the annual fire/life safety survey conducted on August 19, 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 Bubank Health Facility Surveyor Facility Fire Safety and Construction	K 000		
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Building construction type and height meets one of the following: 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This Standard is not met as evidenced by: Based on observation, the facility failed to ensure the fire resistive properties of the structure were maintained. Failure to ensure the fire-resistive properties of limited combustible materials as designed could increase the potential for structural failure during a fire. This deficient practice affected staff and visitors of the IT room across from the nurse's station. The facility is licensed for 16 SNF beds and had a census of 11 on the day of the survey.  Findings include:	K 012	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The deficiency was found to have caused no actual harm to any residents.  2. 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? All residents on TCU have potential to be affected.	8/20/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 9/10/16
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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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135115	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE NF FLOOR  B. WING _____	(X3) DATE SURVEY COMPLETED  08/19/2016
NAME OF PROVIDER OR SUPPLIER EASTERN IDAHO REGIONAL MEDICAL CENTI		STREET ADDRESS, CITY, STATE, ZIP CODE 3100 CHANNING WAY. 83404-7533 IDAHO FALLS, ID 83403		
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K 012	Continued From page 1 During the facility tour conducted on August 19, 2016 from approximately 9:30 AM to 12:30 PM, observation of the steel support beams of the roof/ceiling area in the IT space revealed the fire protective coating on the beams was missing in three locations, ranging in size from approximately six inches by six inches to three inches by two feet.  Actual NFPA standard:  19.1.6.3 All interior walls and partitions in buildings of Type I or Type II construction shall be of noncombustible or limited-combustible materials. Exception*: Listed, fire-retardant-treated wood studs shall be permitted within non-load bearing 1-hour fire-rated partitions.	K 012	3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? A fire resistant protective coating was applied to deficient structures by qualified personnel.  4. 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? The TCU Administrator or his designee will make visual rounds with the Director of Engineering or his designee following the completion of any construction project. During these rounds an assessment will be made in regards to validating the integrity of fire protective coating. If any is breached or found to be deficient a new fire retardant protective coating will be applied by qualified personnel.	