



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

September 2, 2016

Darin Dransfield, Administrator  
Bear Lake Memorial Skilled Nursing Facility  
164 South Fifth Street  
Montpelier, ID 83254-1557

Provider #: 135070

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

Dear Mr. Dransfield:

On **August 23, 2016**, a Facility Fire Safety and Construction survey was conducted at **Bear Lake Memorial Skilled Nursing Facility** 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

Darin Dransfield, Administrator  
September 2, 2016  
Page 2 of 4

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 **September 15, 2016**. Failure to submit an acceptable PoC by **September 15, 2016**, may result in the imposition of civil monetary penalties by **October 5, 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 27, 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 27, 2016**. A change in the seriousness of the deficiencies on **September 27, 2016**, may result in a change in the remedy.

Darin Dransfield, Administrator  
September 2, 2016  
Page 3 of 4

The remedy, which will be recommended if substantial compliance has not been achieved by **September 27, 2016**, includes the following:

Denial of payment for new admissions effective **November 23, 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 **February 23, 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 23, 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:

Darin Dransfield, Administrator  
September 2, 2016  
Page 4 of 4

<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 **September 15, 2016**. If your request for informal dispute resolution is received after **September 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135070</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - ENTIRE NF</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/23/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>BEAR LAKE MEMORIAL SKILLED NURSING FACILITY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>164 SOUTH FIFTH STREET MONTPELIER, ID 83254</b>	
(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, fully sprinklered and built in 1977. The nursing facility is separated from the existing hospital by a two hour fire separation wall. The nursing facility has two smoke compartments. The facility is currently licensed for 36 SNF/NF beds.  The following deficiencies were cited during the annual fire/life safety survey conducted on August 23, 2016. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.  The Survey was conducted by:  Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction  Nate Elkins Supervisor Facility Fire Safety & Construction	K 000	weekly inspections of the hood and filtration systems.  This corrective action will occur by <b>9/27/2016</b> . For follow-up, BLMH SNF will send a copy of the new cleaning schedule for the hood and filtration systems.	9/27/16
K 011 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors with at least 1 1/2 hour fire resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by:	K 011		

RECEIVED  
SEP 19 2016  
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Ronnie R. [Signature]* TITLE: *Administrator* (X6) DATE: *9-13-2016*

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 011	<p>Continued From page 1</p> <p>Based on observation and interview the facility failed to ensure the two hour fire rated wall separating the hospital and the skilled nursing facility was maintained without penetrations. Failure to maintain the two hour fire separation wall could allow fire and smoke to penetrate through the wall and endanger both occupancies. This deficient practice affected 18 residents, staff and visitors on the date of the survey. The facility is licensed for 36 SNF/NF beds with a census of 32 on the day of the survey.</p> <p>Findings Include:</p> <p>During the facility tour on August 23, 2016 from 11:00 AM to 2:00 PM, observation of the two hour fire wall separating the skilled nursing facility and the hospital above the drop down ceiling revealed an approximately 3" X 6" penetration along a large pipe. Upon further investigation, it was discovered that fire stop pillows were loosely stacked, showing open penetrations through the wall. When asked, the Maintenance Supervisor stated the facility was unaware of the penetrations in the two hour fire wall.</p> <p>Actual NFPA standard: 19.1.2.1* Sections of health care facilities shall be permitted to be classified as other occupancies, provided that they meet all of the following conditions: (1) They are not intended to serve health care occupants for purposes of housing, treatment, or customary access by patients incapable of self-preservation. (2) They are separated from areas of health care occupancies by construction having a fire resistance rating of not less than 2 hours</p>	K 011	<p>The alleged deficiency K 011 specifically found a 3"x 6" penetration along a pipe, penetrating through the fire wall located between the skilled nursing home and hospital. In addition, fire stop pillows were loosely stacked, allowing open penetrations through the wall. The deficiency will be corrected as follows:</p> <p>First: The maintenance supervisor will seal the penetration along the pipe with Rock Wool fire block. In addition, the "fire stop" pillows will be secured so that all penetrations are eliminated.</p> <p>Second: The maintenance supervisor will perform an inventory of the area for similar issues, especially in zones of current and past construction projects.</p> <p>Third: To ensure the deficiency does not reoccur, the maintenance supervisor will oversee and perform an inspection of the fire walls during and after new construction or remodels. The maintenance department will keep a record of inventories, problems, and corrections made.</p>		

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K 018 SS=E	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>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 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 and operational testing, the facility failed to ensure that corridor doors would latch. Failure of corridor doors to latch could allow smoke and dangerous gases to pass freely affecting egress during a fire event and hinder the ability to defend in place. This deficient practice affected 18 residents, staff and visitors in 1 of 2 smoke compartments on the date of the survey. The facility is licensed for 36 SNF/NF beds and had a census of 32 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour on August 23, 2016, from approximately 11:00 AM to 2:00 PM, operational testing and observation revealed the following doors would not latch:</p>	K 018	<p>Lastly, the corrective action will be completed by <b>9/27/16</b>. For follow-up, a photo of the completed corrections will be sent to the Bureau of Facility Standards upon completion.</p> <p>The alleged deficiency K018 reports two doors protecting corridor openings that did not latch, namely the Medication Room and South Chapel Door. The deficiency will be corrected as follows:</p> <p>First, the maintenance supervisor will repair both protective doors so that they latch securely.</p> <p>Second, the maintenance supervisor will check other protective doors in the facility to certify that they latch properly.</p> <p>Third, the administrator will teach the purpose of protective doors and their role in preventing fire during the next staff in-service (9/15/2016). The staff will be trained to alert the facilities DNS or Administrator if a protective door is not latching properly. Once</p>		

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K 018	Continued From page 3 -Med Room (located behind the Nurses Station) -Chapel When asked, the Maintenance Supervisor stated that the facility was not aware that the doors would not latch.  Actual NFPA standard:  19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2. 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: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in service.	K 018	alerted, the administrator or DNS will inform the maintenance supervisor through a verbal or written work order to repair the door. The maintenance department will keep a record of inventories, problems, and corrections made.  The corrective action will be completed by <b>9/27/16</b> .		
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:	K 025	The alleged deficiency K025 revealed two inadequacies in smoke walls as noted first by an observed 10" by 12" inch hole in the closet ceiling of room 113. Additionally, multiple penetrations were noted between the two smoke compartments, located near the north tub room, ranging from		

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K 025	<p>Continued From page 4</p> <p>Based on operational testing, 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 during a fire event. This deficient practice affected 32 residents, staff, and visitors on the date of survey. The facility is licensed for 36 SNF/NF beds with a census of 32 on the day of the survey.</p> <p>Findings Include:</p> <p>1.) During the facility tour on August 23, 2016, from approximately 11:00 AM to 2:00 PM, observation of the closet ceiling in resident room 113 revealed an approximately 10" X 12" hole that would not resist the passage of smoke. When asked, the Maintenance Supervisor stated the facility was unaware of the hole in the ceiling.</p> <p>2.) During the facility tour on August 23, 2016, from approximately 11:00 AM to 2:00 PM, observation of the one hour smoke wall separating the two smoke compartments found multiple penetrations ranging in size from approximately 4" X 6" to 2" X 2". These penetrations would not resist the passage of smoke. When asked, the Maintenance Supervisor stated the facility was not aware of the penetrations.</p> <p>Actual NFPA standard:</p> <p>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,</p>	K 025	<p>2"x 2" to 4"x 6". Neither observation would resist the passage of smoke. The deficiency will be corrected as follows:</p> <p>First: The maintenance supervisor will seal the holes in both areas in order to resist the passage of smoke as outlined in this standard.</p> <p>Second: The maintenance supervisor will perform an inventory of the area for similar issues, especially in zones of current and past construction projects.</p> <p>Third: The maintenance supervisor will perform an inspection on new construction or remodels to ensure that the no penetrations exist in smoke walls. The maintenance department will keep a record of inventories, problems, and corrections made.</p> <p>Lastly, the corrective action will be completed by <b>9/27/16</b>. For follow-up, a photo of the completed corrections will be sent to the Bureau of Facility Standards upon completion.</p>		

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K 025	Continued From page 5 smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with 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		
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on record review, observation and	K 062	The alleged deficiency K062 was observed to be in violation as evidenced by escutcheon rings missing from sprinklers in the following locations: room 113, room 103, and the public restroom. The deficiency will be corrected as follows:  First: The maintenance supervisor will attach escutcheon rings onto the sprinkler heads in violation.  Second: The maintenance supervisor will perform an inventory of the other sprinkler heads in the facility.  Third: In the future, the maintenance supervisor will coordinate routine inspections of the sprinkler heads to ensure that all escutcheon rings are present and that the heads are free from paint, corrosion, damage, or any other compromising factors. In addition, the SNF administrator will teach the staff to observe and report	

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K 062	<p>Continued From page 6</p> <p>interview, the facility failed to inspect and maintain sprinkler systems in reliable operating condition. Failure to inspect and test sprinklers could result with inadequate sprinkler system operation during a fire event. This deficient practice affected 32 residents, staff and visitors on the date of the survey. The facility is licensed for 36 SNF/NF beds and had a census of 32 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour on August 23, 2016 from 11:00 AM to 2:00 PM, observation of sprinkler pendants revealed missing escutcheon rings in the following locations:</p> <ul style="list-style-type: none"> <li>-Resident Room 103</li> <li>-Resident Room 113</li> <li>-The public restroom</li> </ul> <p>When asked, the Maintenance Supervisor stated the facility was unaware that the escutcheon rings were missing.</p> <p>Actual NFPA standard:</p> <p>NFPA 25 2-2.1 Sprinklers. 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. Exception No. 1*: Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Sprinklers installed in areas that</p>	K 062	<p>any missing escutcheon rings during in-service on September 15, 2016.</p> <p>Fourth: The maintenance department will keep a record of inventories, problems, and corrections made during these inspections.</p> <p>Finally, this corrective action will be completed by <b>9/27/16</b>. For follow-up, a photo of the completed corrections will be sent to the Bureau of Facility Standards upon completion.</p>		

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

PRINTED: 09/02/2016  
FORM APPROVED  
OMB NO. 0938-0391

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K 062	Continued From page 7 are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown.	K 062	The alleged deficiency K064 points out that the portable fire extinguisher located adjacent to the Beauty Salon was 66" from floor to the top of the extinguisher. The regulation requirement is no more than 60 inches from floor to top of extinguisher. This deficiency will be corrected as follows:		
K 064 SS=E	NFPA 13 3-2.7 Escutcheon Plates. 3-2.7.1 Nonmetallic escutcheon plates shall be listed. 3-2.7.2* Escutcheon plates used with a recessed or flush-type sprinkler shall be part of a listed sprinkler assembly. 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 observation and interview, the facility failed to ensure that fire extinguishers were installed per NFPA 10. Failure to install fire extinguishers at the proper height could hinder emergency response by staff. This deficient practice affected 18 residents, staff and visitors in one of two smoke compartments on the date of the survey. The facility is licensed for 36 SNF/NF beds and had a census of 32 on the day of the survey.  Findings include:  During the facility tour on August 23, 2016 from approximately 11:00 AM to 2:00 PM, examination of the fire extinguisher located near the Beauty Salon revealed the height to the top of the extinguisher was sixty six inches (66"). When	K 064	First, the maintenance supervisor will lower the portable fire extinguisher to the proper height of 5ft. or less.  Second, the maintenance supervisor will inventory all other portable extinguishers in the SNF to ensure they meet the proper height regulations.  Third, the maintenance supervisor will ensure that any future placement of extinguishers from new construction or other purposes will be at the proper height.  Fourth, the maintenance supervisor will keep a record of inventories, problems, and corrections performed to extinguishers.  Lastly, the corrective action will be completed by <b>9/27/16</b> . For follow-up, a photo of the completed corrections		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135070</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - ENTIRE NF</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/23/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>BEAR LAKE MEMORIAL SKILLED NURSING FACILITY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>164 SOUTH FIFTH STREET MONTPELIER, ID 83254</b>		
(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 064	Continued From page 8 asked, the Maintenance Supervisor stated the facility was not aware of the height requirement for fire extinguishers.  Actual NFPA standard:  NFPA 10 1-6.10 Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor. Fire extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be so installed that the top of the fire extinguisher is not more than 31/2 ft (1.07 m) above the floor. In no case shall the clearance between the bottom of the fire extinguisher and the floor be less than 4 in. (10.2 cm).	K 064	will be sent to the Bureau of Facility Standards upon completion.		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)  This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the generator of the Emergency Power Supply System (EPSS) was inspected weekly and tested monthly in accordance with NFPA 110. Failure to inspect and test EPSS generators could result in a lack of system reliability during a power loss. This deficient practice affected 32 residents, staff and visitors on the date of the survey. The facility is licensed for 36 SNF/NF residents and had a census of 32 on the day of the survey.	K 144			

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NAME OF PROVIDER OR SUPPLIER  <b>BEAR LAKE MEMORIAL SKILLED NURSING FACILITY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>164 SOUTH FIFTH STREET MONTPELIER, ID 83254</b>	
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K 144	Continued From page 9  Findings include:  1) During review of the the facility generator inspection and testing reports conducted on August 23, 2016, reports indicated missing weekly inspections.  2) During review of the the facility generator inspection and testing reports conducted on August 23, 2016, reports indicated missing monthly load tests. In addition to the missing documentation, the monthly load test form did not indicate loads.  When asked, the Maintenance Supervisor stated the facility was unaware the documentation for testing was missing or that they were required to document the load on the monthly load test form.  Actual NFPA standard:  NFPA 99  3-4.4.1 Maintenance and Testing of Essential Electrical System. 3-4.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches. (a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-4.3.1. Maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6. (b) Inspection and Testing.	K 144	The alleged deficiency K144 demonstrated that the facility failed to perform and record weekly generator inspections. In addition, reports indicated missing monthly load tests. This deficiency will be corrected as follows:  First, the maintenance supervisor will acquire software from Caterpillar to perform weekly run tests and monthly load tests of the generator. Until the software is installed, maintenance will perform manual weekly inspections and monthly load tests.  Second, the data and reports provided by the software or manual inspections will be reviewed and inspected regularly by the maintenance supervisor.  Third, the maintenance supervisor will keep a record of any problems and corrections made to the generator.  Lastly, the corrective action will be completed by <b>9/27/16</b> . For follow-up, a photo of the completed corrections will be sent to the Bureau of Facility Standards upon completion.	

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K 144	<p>Continued From page 10</p> <p>1. * Test Criteria. Generator sets shall be tested twelve (12) times a year with testing intervals between not less than 20 days or exceeding 40 days. Generator sets serving emergency and equipment systems shall be in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6.</p> <p>2. Test Conditions. The scheduled test under load conditions shall include a complete simulated cold start and appropriate automatic and manual transfer of all essential electrical system loads.</p> <p>3. Test Personnel. The scheduled tests shall be conducted by competent personnel. The tests are needed to keep the machines ready to function and, in addition, serve to detect causes of malfunction and to train personnel in operating procedures.</p> <p>3-3.4.3 Recordkeeping. 3-3.4.3.1* General. A record shall be maintained of the tests required by this chapter and associated repairs or modification. At a minimum, this record shall contain the date, the rooms or areas tested, and an indication of which items have met or have failed to meet the performance requirements of this chapter.</p> <p>NFPA 110 Chapter 6 6-4 Operational Inspection and Testing. 6-4.1* Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly. Exception: If the generator set is used for standby power or for peak load shaving, such use shall be recorded and shall be permitted to be</p>	K 144			

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K 144	Continued From page 11 substituted for scheduled operations and testing of the generator set, provided the appropriate data are recorded. 6-4.2* Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (a) Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating (b) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer The date and time of day for required testing shall be decided by the owner, based on facility operations.	K 144			

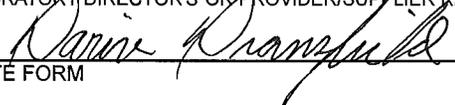
Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001030</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01 - ENTIRE NF</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/23/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BEAR LAKE MEMORIAL SKILLED NURSING F</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>164 SOUTH FIFTH STREET MONTPELIER, ID 83254</b>
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C 000	<p><b>16.03.02 INITIAL COMMENTS</b></p> <p>The facility is a single story type V (111) construction, fully sprinklered and built in 1977. The nursing facility is separated from the existing hospital by a two hour fire separation wall. The nursing facility has two smoke compartments. The facility is currently licensed for 36 SNF/NF beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on August 23, 2016. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70. The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities found in IDAPA 16.03.02.</p> <p>The Survey was conducted by:</p> <p>Linda Chaney Health Facility Surveyor Facility Fire Safety &amp; Construction</p> <p>Nate Elkins Supervisor Facility Fire Safety &amp; Construction</p>	C 000	<p>RECEIVED SEP 19 2016 FACILITY STANDARDS</p>	
C 260	<p><b>02.106,07,h Weekly Cleaning of Range Hoods/Filters</b></p> <p>h. All range hoods and filters shall be cleaned at least weekly. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to maintain kitchen hood and filter systems. Failure to maintain kitchen hood and filter systems could result in grease and other combustible material building up on the hood and</p>	C 260		

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 9-13-2016
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C 260	<p>Continued From page 1</p> <p>filters potentially causing a fire event. This deficient practice affected staff and visitors on the date of the survey. The facility is licensed for 36 SNF/NF beds and had a census of 32 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour on August 23, 2016, at approximately 11:00 AM to 2:00 PM, observation of the hood and filters in the kitchen revealed they were dirty and appeared to have a greasy build up. When asked, the Dietary Supervisor stated staff cleaned the hood and filters a couple of times a month, if they had time.</p>	C 260	<p>The alleged deficiency C260 specifically found the kitchen hood and filters to have a greasy build up. It was attained through interview with the Dietary Supervisor the hood was cleaned just a couple of times per month.</p> <p>The deficiency will be corrected as follows:</p> <p>First: To be in compliance, the Dietary Supervisor will adopt a weekly cleaning schedule for the kitchen hood and filter systems.</p> <p>Second: The Dietary Supervisor will train her staff members during September's in-servicee to understand regulatory cleaning requirements of the hood and ventilation system. In addition, the Dietary Supervisor will introduce the hood cleaning schedule to the staff.</p> <p>Third: To ensure the deficient practice does not occur, the Dietary Supervisor will monitor and record progress of the cleaning schedule with</p>	
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