



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

Dallas Clinger, Administrator
Power County Nursing Home
PO Box 420
American Falls, ID 83211-0420

Provider #: 135066

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

Dear Mr. Clinger:

On **August 25, 2016**, a Facility Fire Safety and Construction survey was conducted at **Power County Nursing Home** 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 one that comprises a pattern 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 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 29, 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 29, 2016**. A change in the seriousness of the deficiencies on **September 29, 2016**, may result in a change in the remedy.

Dallas Clinger, Administrator
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The remedy, which will be recommended if substantial compliance has not been achieved by **September 29, 2016**, includes the following:

Denial of payment for new admissions effective **November 25, 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 25, 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 25, 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:

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<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

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

PRINTED: 09/01/2016
FORM APPROVED
OMB NO. 0938-0391

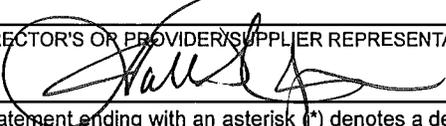
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135066	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 08/25/2016
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NAME OF PROVIDER OR SUPPLIER POWER COUNTY NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 510 ROOSEVELT STREET (83211-1362) AMERICAN FALLS, ID 83211
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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	<p>INITIAL COMMENTS</p> <p>The nursing facility portion of the building occupies the east wing of both the lower and upper levels and is attached to the hospital building. The original building's construction was completed in early 1961 and consisted of the lower level east wing nursing facility and the west lower and upper level hospital portion. A two level addition was completed in early 1967 extending the upper level hospital patient wing to the east. The nursing facility was extended into the upper level east wing sleeping rooms in the fall of 1987. Both the existing and addition building construction elements are fire resistive. Wall construction varies depending upon location and is either concrete block; concrete; concrete with brick veneer; and/or 4"/6" metal studs w/lath & plaster. Supporting beams are combination steel w/fire proofing and/or concrete. The floor/ceiling assembly between the lower and upper levels consist of steel joist with 5/8" gyp steel channel below and metal decking and poured concrete flooring above. The roof assembly is steel joists with lath/plaster attached to the underside and a metal deck with poured concrete above. There are a total of three (3) exits from the lower level nursing facility wing; two (2) directly to the exterior at grade and the third through the hospital's main entry lobby. There are two (2) exits from the upper level east nursing wing; one is an enclosed stairway at the east end of the wing and the other is accessible through the west hospital portion of the building. The building is provided with a fire alarm system with off site monitoring and system smoke detection in the exit access corridors and the open dining room on the lower level. Portable fire extinguishers are provided and are multipurpose ABC with additional K style for</p>	K 000		
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RECEIVED
SEP 19 2016
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE CEO/ADMINISTRATOR	(X6) DATE 14 SEP 2016
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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.

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

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OMB NO. 0938-0391

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K 000	Continued From page 1 protection in the kitchen area. Emergency power and lighting are provided by the hospital's diesel powered, automatic generator. The facility was retrofitted on October 4, 2010 with automatic fire sprinklers, a Halon system was also installed in the IT room, both systems are interconnected with the building fire alarm system. The facility is currently licensed for 20 SNF/NF beds. The following deficiencies were cited during the annual life safety code survey conducted on August 25, 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: Nate Elkins, Supervisor Facility Fire Safety & Construction Program Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction Program NFPA 101 LIFE SAFETY CODE STANDARD	K 000			
K 018 SS=D	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 1 3/4 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	K 018	K018 NFPA 101 What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice? The Maintenance Staff took a small file to the strike plate of the door and filed the opening so that the door latched freely. This work was done on August 26, 2016. All doors will be checked by the maintenance staff monthly with the door audits already in place. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken? All residents, staff, and visitors have the potential to be affected by this deficiency.	15SEPT16	

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K 018	<p>Continued From page 2</p> <p>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, operational testing, and interview the facility failed to maintain doors that protect corridor openings. Failure to maintain corridor doors could allow smoke and dangerous gases to pass freely through smoke barriers. This deficient practice affected 17 residents, staff, and visitors on the date of survey. The facility is licensed for 20 SNF/NF beds with a census of 17 on the day of survey.</p> <p>Findings include:</p> <p>During the facility tour on August 25, 2016 at approximately 11:00 AM, observation and operational testing of the door leading to room 7 revealed it would not close and latch properly. When asked, the Maintenance Supervisor stated the facility was unaware of the resident room door not latching properly.</p> <p>Actual NFPA standard: 19.3.6.3 Corridor Doors. 19.3.6.3.1* 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-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire</p>	K 018	<p>What measure will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>The Maintenance Staff will inspect all doors on a monthly basis to check that they latch properly to ensure compliance with the smoke barrier requirements.</p> <p>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?</p> <p>The Maintenance Staff will monitor all doors on a monthly basis when they check the doors for proper functioning.</p>	

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K 018	Continued From page 3 Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. 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: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 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			
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and	K 025			

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K 025	<p>Continued From page 4</p> <p>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.</p> <p>8.3, 19.3.7.3, 19.3.7.5</p> <p>This STANDARD is not met as evidenced by: Based on 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 affecting protection in place during a fire event. This deficient practice affected staff and visitors on the date of the survey. The facility is licensed for 20 SNF/NF beds and had a census of 17 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour on August 25, 2016 between 9:00 AM and 11:30 PM, observation of the ceiling in the autoclave room revealed a penetration that would not resist the passage of smoke. When asked the Maintenance Supervisor stated the facility was unaware of the penetration.</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, 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.</p>	K 025	<p>K025 NFPA 101</p> <p>What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice?</p> <p>The unsealed hole in the second floor Autoclave room ceiling was sealed with fire caulking on August 25, 2016, following the inspection.</p> <p>How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?</p> <p>All residents, staff, and visitors have the potential to be affected by this deficiency.</p> <p>What measure will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>The Maintenance staff will inspect all outside contractor work upon completion to ensure that the contractor has sealed all areas worked on sufficiently or they will complete the seal work to ensure compliance with the smoke barrier requirements.</p> <p>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?</p> <p>The Maintenance Staff will monitor all new maintenance wall work done by outside contractors that could affect smoke barriers to ensure compliance with fire sealing standards.</p>	15SEPT16

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K 025	Continued From page 5 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 NFPA 101 LIFE SAFETY CODE STANDARD	K 025	K147 NFPA 101 1. Missing Blanks inside breaker panels and junction boxes What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice? The Maintenance Staff called an electrical contractor, Hunt Electric, and the owner, John Hunt came over on Monday, August 29, 2016 and installed covers on the kitchen panels. The Maintenance Staff went to the local metal fabrication company and had a cover built for the panel in the mechanical room. This work was completed on September 9, 2016 How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken? All residents, staff, and visitors have the potential to be affected by this deficiency. What measure will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur? The Maintenance staff will inspect the work of the electrical contractors upon completion to ensure that the contractor has covered all missing blanks in electrical panels.	15SEPT16
K 147 SS=E	Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure electrical installations were in accordance with the National Electrical Code. This deficient practice affected staff and visitors on the date of survey. The facility is licensed for 20 SNF/NF beds with a census of 17 the day of survey.	K 147		

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K 147	<p>Continued From page 6</p> <p>Findings include:</p> <p>1.) During the facility tour on August 25, 2016, between 9:00 AM to 11:30 AM, the following areas were observed to have missing blanks inside the breaker panel junction boxes to cover openings: Kitchen area near dishwasher Kitchen area near the door Two (2) electrical panels near main entrance Mechanical Room When asked, the Maintenance Supervisor stated the facility was unaware of the missing blanks.</p> <p>2.) During the facility tour on August 25, 2016, between 9:00 AM and 11:30 PM, observation of the server room revealed a zip cord being utilized as a substitute for fixed wiring. When asked, the maintenance Supervisor stated the facility was unaware of the zip cord</p> <p>3.) During the facility tour on August 25, 2016 between 9:00 AM and 11:30 PM, observation of the Skilled Nursing Office revealed a refrigerator plugged into relocatable power tap being utilized as fixed wiring. When asked, the Maintenance Supervisor stated the facility was unaware of the refrigerator plugged into into a Relocatable Power Tap (RPT).</p> <p>Actual NFPA standard:</p> <p>NFPA 70 National Electrical Code 1999 Edition 400-8. Uses Not Permitted Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following: 1. As a substitute for the fixed wiring of a structure</p>	K 147	<p>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?</p> <p>The Maintenance Staff will monitor all new electrical work done by outside contractors to ensure compliance with regulations and standards.</p> <p>2. Zip cord used instead of fixed wiring.</p> <p>What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice?</p> <p>The Maintenance Staff called an electrical contractor, Hunt Electric, and the owner, John Hunt came over on Monday, August 29, 2016 and installed emergency power (fixed wiring) in the server room. This work was completed on August 29, 2016</p> <p>How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?</p> <p>All residents, staff, and visitors have the potential to be affected by this deficiency.</p> <p>What measure will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>The Maintenance Staff spoke with the IT staff to make sure they were aware of the Fire and Life Safety requirements regarding the use of</p>	

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NAME OF PROVIDER OR SUPPLIER POWER COUNTY NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 510 ROOSEVELT STREET (83211-1362) AMERICAN FALLS, ID 83211		
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K 147	<p>Continued From page 7</p> <p>2. Where run through holes in walls, structural ceilings suspended ceilings, dropped ceilings, or floors</p> <p>3. Where run through doorways, windows, or similar openings</p> <p>4. Where attached to building surfaces Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-8.</p> <p>5. Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors</p> <p>6. Where installed in raceways, except as otherwise permitted in this Code</p> <p>Also see UL listings: XBYS Guide information XBZN2 Guide information 110.12 Mechanical Execution of Work. Electrical equipment shall be installed in a neat and workmanlike manner. (A) Unused Openings. Unused cable or raceway openings in boxes, raceways, auxiliary gutters, cabinets, cutout boxes, meter socket enclosures, equipment cases, or housings shall be effectively closed to afford protection substantially equivalent to the wall of the equipment. Where metallic plugs or plates are used with nonmetallic enclosures, they shall be recessed at least 6 mm (¼ in.) from the outer surface of the enclosure. (B) Subsurface Enclosures. Conductors shall be racked to provide ready and safe access in underground and subsurface enclosures into which persons enter for installation and maintenance. (C) Integrity of Electrical Equipment and Connections. Internal parts of electrical equipment, including busbars, wiring terminals, insulators, and other surfaces, shall not be</p>	K 147	<p>extension cords to provide emergency power to the servers.</p> <p>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?</p> <p>The Maintenance Staff in conjunction with the IT Staff will monitor the server room to ensure compliance with regulations and standards.</p> <p>3. Refrigerator plugged into relocatable power tap.</p> <p>What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice?</p> <p>The Maintenance Staff removed the relocatable power tap and plugged the refrigerator directly into the wall.</p> <p>How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?</p> <p>All residents, staff, and visitors have the potential to be affected by this deficiency.</p> <p>What measure will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>The Maintenance Staff sent an email to all managers explaining the proper use of</p>	

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

PRINTED: 09/01/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135066	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 08/25/2016
NAME OF PROVIDER OR SUPPLIER POWER COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 510 ROOSEVELT STREET (83211-1362) AMERICAN FALLS, ID 83211		
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K 147	Continued From page 8 damaged or contaminated by foreign materials such as paint, plaster, cleaners, abrasives, or corrosive residues. There shall be no damaged parts that may adversely affect safe operation or mechanical strength of the equipment such as parts that are broken; bent; cut; or deteriorated by corrosion, chemical action, or overheating.	K 147	relocatable power taps and the improper uses. They were instructed to notify the Maintenance Staff if they needed to install a relocatable power tap. 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 Maintenance Staff will monitor the use of relocatable power taps to ensure compliance with regulations and standards.		

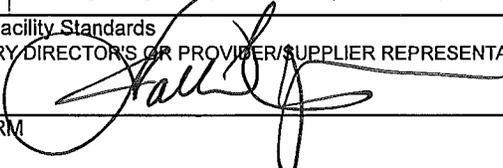
Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDS001630	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 08/25/2016
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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The nursing facility portion of the building occupies the east wing of both the lower and upper levels and is attached to the hospital building. The original building's construction was completed in early 1961 and consisted of the lower level east wing nursing facility and the west lower and upper level hospital portion. A two level addition was completed in early 1967 extending the upper level hospital patient wing to the east. The nursing facility was extended into the upper level east wing sleeping rooms in the fall of 1987. Both the existing and addition building construction elements are fire resistive. Wall construction varies depending upon location and is either concrete block; concrete; concrete with brick veneer; and/or 4"/6" metal studs w/lath & plaster. Supporting beams are combination steel w/fire proofing and/or concrete. The floor/ceiling assembly between the lower and upper levels consist of steel joist with 5/8" gyp steel channel below and metal decking and poured concrete flooring above. The roof assembly is steel joists with lath/plaster attached to the underside and a metal deck with poured concrete above. There are a total of three (3) exits from the lower level nursing facility wing; two (2) directly to the exterior at grade and the third through the hospital's main entry lobby. There are two (2) exits from the upper level east nursing wing; one is an enclosed stairway at the east end of the wing and the other is accessible through the west hospital portion of the building. The building is provided with a fire alarm system with off site monitoring and system smoke detection in the exit access corridors and the open dining room on the lower level. Portable fire extinguishers are provided and are multipurpose ABC with additional K style for protection in the kitchen area. Emergency power and lighting are provided by the hospital's diesel</p>	C 000	<p style="text-align: center;">RECEIVED SEP 19 2016 FACILITY STANDARDS</p>	
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Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE CEO/ADMINISTRATOR	(X6) DATE 14 SEP 2016
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Bureau of Facility Standards

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C 000	Continued From page 1 powered, automatic generator. The facility was retrofitted on October 4, 2010 with automatic fire sprinklers, a Halon system was also installed in the IT room, both systems are interconnected with the building fire alarm system. The facility is currently licensed for 20 SNF/NF beds. The following deficiencies were cited during the annual life safety code survey conducted on August 25, 2016. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70 and IDAPA 16.03.02 Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities. The survey was conducted by: Nate Elkins, Supervisor Facility Fire Safety & Construction Program Linda Chaney Health Facility Surveyor Facility Fire Safety & Construction Program	C 000		
C 260	02.106,07,h Weekly Cleaning of Range Hoods/Filters 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 clean grease hood filters weekly in accordance with IDAPA 16.03.02. Failure to clean hood filters could allow radiant heat to ignite the grease on the hood filters. This deficient practice affected staff and visitors on the date of survey. The facility is licensed for 20 SNF/NF beds with a census of 17 on the day of survey.	C 260	C260 02.106,07,h What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice? Kitchen hood filters will be cleaned by the Dietary Staff on a weekly basis. On August 26, 2016, the Maintenance Staff trained the Dietary Staff in the proper methods of cleaning the hood filters as well as the proper interval (each week). A filter removal tool was ordered and received on September 7, 2016, to facilitate the removal and reinstallation of the filters. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken? All residents, staff, and visitors have the potential to be affected by this deficiency.	15SEPT16

Bureau of Facility Standards

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C 260	Continued From page 2 Findings include: During the facility tour on August 25, 2016 at approximately 10:00 AM, observation of the kitchen hood system revealed a slight build up of grease. When interviewing the staff on duty it was revealed that the facility was not cleaning the hood filters on a weekly basis.	C 260	What measure will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur? The Dietary Staff will sign off on a sheet documenting the date time and staff member who cleans the hood filter <i>on a weekly basis</i> 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 Dietary Staff will maintain the records of the hood cleaning to monitor that it is cleaned weekly to ensure compliance with standards and regulations.	