



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 28, 2016

Mark Teckmeyer, Administrator
Bingham Memorial Skilled Nursing & Rehabilitation
98 Poplar Street
Blackfoot, ID 83221-1758

Provider #: 135007

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

Dear Mr. Teckmeyer:

On **September 20, 2016**, a Facility Fire Safety and Construction survey was conducted at **Bingham Memorial Skilled Nursing & Rehabilitation** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to

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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 **October 11, 2016**. Failure to submit an acceptable PoC by **October 11, 2016**, may result in the imposition of civil monetary penalties by **October 31, 2016**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567. If a State Form was issued as well, it should also be signed, dated and returned.

All references to federal regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **October 25, 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 **October 25, 2016**. A change in the seriousness of the deficiencies on **October 25, 2016**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **October 25, 2016**, includes the following:

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Denial of payment for new admissions effective **December 20, 2016**.
42 CFR §488.417(a)

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **March 20, 2017**, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; 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 **September 20, 2016**, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

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

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

BFS Letters (06/30/11)

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

This request must be received by **October 11, 2016**. If your request for informal dispute resolution is received after **October 11, 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: 09/27/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135007	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE NF B. WING _____	(X3) DATE SURVEY COMPLETED 09/20/2016
NAME OF PROVIDER OR SUPPLIER BINGHAM MEMORIAL SKILLED NURSING & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 98 POPLAR STREET BLACKFOOT, ID 83221	
(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 (III) structure with a two hour fire wall to the JCAHO accredited hospital. The facility was originally built in 1963 with renovation and addition in 1999. The building is fully sprinklered and is licensed for 70 beds. The following deficiencies were cited during the annual fire/life safety survey conducted on September 20, 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	K 000	The following Plan of Correction is submitted by the facility in accordance with the pertinent terms of provisions of 42CFR Section 488 and/or related state regulations, and is intended to serve as a credible allegation of our intent to correct the practices identified as deficient. The Plan of Correction should not be construed or interpreted as an admission that the deficiencies alleged did, in fact, exist; rather, the facility is filing this document in order to comply with its obligations as a provider participating in the Medicare / Medicaid program(s).	
K 018 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD 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	K 018	K018 The Main Dining Room Door with the 1/2 "gap on closure has been repaired J. Sellers, Maintenance Technician. This door was inspected by the NHA and concurs the door seal is tight enough not even to allow light to pass. The Resident Room Doors were gaps existed were repaired to meet smoke barrier compliance. The necessary hardware has been purchased.	RECEIVED OCT 11 2016 FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

[Signature] NHA 10.07.16

* Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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 018	<p>Continued From page 1</p> <p>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 between compartments. This deficient practice has affected 43 residents, staff, and visitors on the date of survey. The facility is licensed for 70 SNF/NF beds with a census of 43 on the day of survey.</p> <p>Findings include:</p> <p>1.) During the facility tour on September 20, 2016 from approximately 9:00 AM to 2:30 PM, observation of the doors at the main Dining Room revealed the doors had an approximately 1/2" gap between the leading edges of the doors when fully closed. When asked, the Administrator and Maintenance Supervisor stated that the facility was unaware the doors did not seal completely.</p> <p>2.) During the facility tour on September 20, 2016 from approximately 9:00 AM to 2:30 PM, observation of the resident room doors revealed that most resident room doors had an inactive leaf (70/30 door). Where the door and leaf met, there was a 1/4" gap between the doors. A brush seal was installed to seal the gap, but was damaged or missing at either the top or bottom of the door (or both) leaving an approximately 1/4" X 3" gap when closed. When asked, the Administrator and Maintenance Supervisor stated that the facility was unaware that the doors were not sealing properly.</p> <p>Actual NFPA standard:</p>	K 018	<p>All residents have the potential to be affected. Maintenance Department will conduct an audit to see if any other resident room doors have gaps greater than 1/4" and correct those that are non-compliant.</p> <p>An audit of our resident room door and dining room doors will be conducted weekly for four weeks. Then, monthly for two months to assure we are in compliance. All doors not meeting compliance will be repaired within five business days. If a repair is not feasible the Engineering Director will develop a solution which will meet compliance.</p> <p>The QAPI committee will review the data monthly to assure proper compliance is met. NHA/designee to verify all repairs are timely and meet compliance standards.</p> <p>September 21, 2016</p>		

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K 018	Continued From page 2 NFPA 101 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 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.	K 018	
K 062 SS=F	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 and interview, the facility failed to maintain sprinkler systems in accordance with NFPA 25. Failure to maintain	K 062	

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K 062	<p>Continued From page 3</p> <p>sprinkler systems as required could result in insufficient suppression during a fire. This deficient practice affected 43 residents, staff and visitors on the date of the survey. The facility is licensed for 70 SNF/NF beds and had a census of 43 on the day of the survey.</p> <p>Findings include:</p> <p>During record review conducted at the facility on September 20, 2016 from approximately 9:00 AM to 10:00 AM, documentation for the five (5) year internal sprinkler pipe inspection could not be located. When asked, the Maintenance Supervisor stated the facility was not aware of the five year inspection requirement.</p> <p>Actual NFPA standard:</p> <p>NFPA 25 10-2* Obstruction Investigation and Prevention. 10-2.1*</p> <p>To ensure that piping remains clear of all obstructive foreign matter, an obstruction investigation shall be conducted for system or yard main piping wherever any of the following conditions exist:</p> <ul style="list-style-type: none"> (a) Defective intake for fire pumps taking suction from open bodies of water (b) The discharge of obstructive material during routine water tests (c) Foreign materials in fire pumps, in dry pipe valves, or in check valves (d) Foreign material in water during drain tests or plugging of inspector 's test connection(s) (e) Plugged sprinklers (f) Plugged piping in sprinkler systems dismantled during building alterations (g) Failure to flush yard piping or surrounding 	K 062	<p>K 062</p> <p>Our sprinkler vendor "Viking Fire Protection" has been contacted by our Engineering Director to establish a date to complete our FIVE year Internal Inspection of our fire suppression system pipes on September 21, 2016. Viking Fire Protection completed our Five Year Internal Pipe inspection on October 6, 2016. The required form with results and remediation to meet compliance will be collected from Viking. Form is still be processed at this time but will be available on our re-inspection date.</p> <p>All residents have the potential to be affected by not having a completed five year internal inspection of our sprinkler pipes.</p> <p>We will require our sprinkler vendor to put us on an automatic five year internal inspection of our systems' pipes schedule. Also, our Engineering Director will submit this data in our work order program.</p>		

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K 062	Continued From page 4 public mains following new installations or repairs (h) A record of broken public mains in the vicinity (i) Abnormally frequent false tripping of a dry pipe valve(s) (j) A system that is returned to service after an extended shutdown (greater than 1 year) (k) There is reason to believe that the sprinkler system contains sodium silicate or highly corrosive fluxes in copper systems (l) A system has been supplied with raw water via the fire department connection. 10-2.2* Obstruction Prevention. Systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This investigation shall be accomplished by examining the interior of a dry valve or preaction valve and by removing two cross main flushing connections. 2-3.2* Gauges. Gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. NFPA 101 LIFE SAFETY CODE STANDARD Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10, 18.2.1, 19.2.1 This STANDARD is not met as evidenced by:	K 062	Corrective action will be monitored by our Engineering Department personnel. Likewise, we will be monitored by our sprinkler vendor for current compliance as well as scheduling us for a five year visit concerning internal inspection of sprinkler system pipes. October 14, 2016	
K 072 SS=F		K 072		

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K 072	<p>Continued From page 5</p> <p>Based on observation, operational testing and interview, the facility failed to ensure that exit doors were arranged to be readily opened from the egress side and not require special knowledge. Failure to maintain means of egress for full instant use could hinder the safe evacuation of residents during an emergency. This deficient practice affected 43 residents, staff and visitors on the date of the survey. The facility is licensed for 70 SNF/NF beds and had a census of 43 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour on September 20, 2016 from approximately 9:00 AM to 2:30 PM, observation and operational testing revealed the following exit doors had controlled access and could not be opened without special knowledge. (code)</p> <ol style="list-style-type: none"> 1.) Exit door at rear of main lobby 2.) Exit door at the end of the 300 corridor. <p>When asked why the doors were controlled access, the Administrator and Maintenance Manager stated the facility installed them for security and were unaware that controlled access exit doors were not allowed. They further stated that the controlled access component would drop in the event of a power outage or activation of the fire alarm system allowing egress.</p> <p>Actual NFPA standard:</p> <p>7.2.1.5 Locks, Latches, and Alarm Devices. 7.2.1.5.1 Doors shall be arranged to be opened readily from the egress side whenever the building is occupied. Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort</p>	K 072	<p>K 072</p> <p>Exit Door near the main Lobby will have a pressure release device installed for mean of egress. We will have Petersen Electric install said device.</p> <p>Exit Door at the end of our 300 hallway will have a pressure release device installed for mean of egress. We will have our fire system vendor install said device.</p> <p>All residents have the potential to be affect by these two doors not allowing exit as defined in NFPA 7.2.1.5 & NFPA 7.2.1.5.1</p> <p>All other exit doors were checked during the life safety survey completed on September 20, 2016 and were found to be in compliance. We will monitor all exit doors weekly for compliance standards. Then, we will check monthly for two months.</p> <p>Our QAPI Committee will check this data on a monthly basis for compliance and/or any remedial action which may be required to be in compliance.</p> <p>October 24, 2016 <i>November 24, 2016</i> <i>Granted extension for compliance via phone/mail - NE</i></p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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K 072	Continued From page 6 for operation from the egress side. Exception No. 1: This requirement shall not apply where otherwise provided in Chapters 18 through 23. Exception No. 2: Exterior doors shall be permitted to have key-operated locks from the egress side, provided that the following criteria are met: (a) Permission to use this exception is provided in Chapters 12 through 42 for the specific occupancy. (b) On or adjacent to the door, there is a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high on a contrasting background that reads as follows: THIS DOOR TO REMAIN UNLOCKED WHEN THE BUILDING IS OCCUPIED NFPA 101 LIFE SAFETY CODE STANDARD	K 072		
K 143 SS=D	Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and (b) the area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area that is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and Compressed Gas Association.	K 143		

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K 143	<p>Continued From page 7</p> <p>8-6.2.5.2 (NFPA 99)</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide a safe environment for the transfilling of oxygen from one container to another. Failure to provide a safe environment for transfilling of oxygen could create an oxygen-enriched atmosphere within the vicinity of the containers. This deficient practice affected 5 residents, staff and visitors on the day of survey. The facility is licensed for 70 SNF/NF beds with a census of 43 on the date of survey.</p> <p>Findings include:</p> <p>During the facility tour on September 20, 2016 at approximately 9:00 AM to 2:30 PM, observation of the oxygen transfilling room in the 500 hallway revealed the mechanical ventilation system was not operational or continuously operating. When asked, the Maintenance Supervisor stated the facility was aware the mechanical ventilation system was not operational and parts had been ordered to repair the system.</p> <p>Actual NFPA standard:</p> <p>NFPA 99</p> <p>8-6.2.5.2 Transferring Liquid Oxygen. Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows:</p> <p>(a) Separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and</p> <p>(b) The area is mechanically ventilated, is</p>	K 143	<p>K 143</p> <p>Our Oxygen Trans filling Room on the 500 Hallway has had the ventilation fan replaced by C. Winterbottom, Lead Technician on September 28, 2016. The NHA, Engineering Director, and Maintenance Personnel verified the fan was replaced as is operational on September 29, 2016.</p> <p>All residents have the potential to be affected by this deficiency.</p> <p>We will check the operational status of the Oxygen Trans filling Room on a weekly basis and then monthly for two months. Non-Compliance findings will be noted with immediate remediation to take place if not operational.</p> <p>Our QAPI Committee will check this data on a monthly basis for compliance and/or any remedial action which may be required to be in compliance.</p> <p>September 28, 2016</p>	

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135007	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE NF B. WING _____		(X3) DATE SURVEY COMPLETED 09/20/2016
NAME OF PROVIDER OR SUPPLIER BINGHAM MEMORIAL SKILLED NURSING & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 98 POPLAR STREET BLACKFOOT, ID 83221		
(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 143	Continued From page 8 sprinklered, and has ceramic or concrete flooring; and (c) The area is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted. Transferring shall be accomplished utilizing equipment designed to comply with the performance requirements and producers of CGA Pamphlet P-2.6, Transfilling of Low-Pressure Liquid Oxygen to be Used for Respiration, and adhering to those procedures. The use and operation of small portable liquid oxygen systems shall comply with the requirements of CGA Pamphlet P-2.7, Guide for the Safe Storage, Handling and Use of Portable Liquid Oxygen Systems in Health Care Facilities.	K 143		