November 21, 2016

Dawn Meyer, Administrator
Lincoln County Care Center
PO Box 830
Shoshone, ID 83352-1502

Provider #: 135056

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Ms. Meyer:

On November 9, 2016, a Facility Fire Safety and Construction survey was conducted at Lincoln County Care Center by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date to signify when you allege that each tag will be back in compliance. NOTE: The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator
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 December 5, 2016. Failure to submit an acceptable PoC by December 5, 2016, may result in the imposition of civil monetary penalties by December 21, 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 December 14, 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 December 14, 2016. A change in the seriousness of the deficiencies on December 14, 2016, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by December 14, 2016, includes the following:
Denial of payment for new admissions effective **February 9, 2017**.
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 **May 9, 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 **November 9, 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:

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 December 5, 2016. If your request for informal dispute resolution is received after December 5, 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
The facility is a single story, type V(111) construction built in 1958. It is fully sprinklered building with smoke detection coverage throughout the facility. There is a partial basement that contains the boiler room, storage, and employee lounge. Currently the facility is licensed for 36 SNF/NF beds.

The following deficiencies were cited during the annual Fire/Life Safety survey conducted on November 9, 2015. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.

The survey was conducted by:

Sam Burbank
Health Facility Surveyor
Facility Fire Safety & Construction

K 161
NFPA 101 Building Construction Type and Height
2012 EXISTING
Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5
1
Construction Type I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered
2
II (111) One story non-sprinklered sprinklered
Maximum 3 stories

RECEIVED
DEC 05 2016
FACILITY STANDARDS

NFPA 101 Building construction
The facility will ensure to maintain the fire and smoke resistive integrity of the building.

The Facility has lowered the gas line, and valve. (11/30/16)

After relocation of pipe and valve the area to the floor will be repaired with Dura rock and fire retarded sealant.

Completed on (11/30/16)
The Maintenance manager has sealed the ceiling in storage room of basement all holes filled with sealant.

Completed on 12/6/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.
NAME OF PROVIDER OR SUPPLIER: LINCOLN COUNTY CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 511 EAST FOURTH STREET SHOSHONE, ID 83352

(K161) Continued From page 1

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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<td>8</td>
<td>V</td>
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<td>Maximum 1 story</td>
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Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5)

Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.

This Standard is not met as evidenced by:

Based on observation, the facility failed to ensure that the fire and smoke resistive properties of the structure were maintained. Failure to seal penetrations between floors could allow fire, smoke and dangerous gases to pass between floors during a fire. This deficient practice affected staff and visitors of the main Kitchen and basement area on the date of the survey. The facility is licensed for 36 SNF/NF beds and had a census of 29 on the day of the survey.

Findings include:

During the facility tour conducted on November 9, 2016 from approximately 11:00 AM to 12:30 PM, observation of the ceiling in the basement Boiler area and the abutting storage room revealed the

All residents, visitors and staff have the potential to be affected by this practice.

Maintenance manager will inspect any vendor services or contractors work upon completion to ensure the smoke and fire integrity of the building is maintain and all holes, or penetrations in wall or ceiling are sealed with fire retarded or sealant.

Please see Exhibit: A

Maintenance Manager to do walking rounds weekly with Administrator or designee, to audit for any possible ceiling openings

Weekly for one month /Bi-weekly for month then monthly there after.

Audits to be reviewed in CQI Monthly and Administrator will sign all audits and do random checks for compliance.
### Statement of Deficiencies and Plan of Correction

**Department of Health and Human Services**

**Centers for Medicare & Medicaid Services**

**Statement of Deficiencies and Plan of Correction**

**Provider/Supplier/CLIA Identification Number:**

135056

**Multiple Construction**

**Building 01 - Entire Building**

** Wing**

11/09/2016

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**Name of Provider or Supplier:**

Lincoln County Care Center

**Street Address, City, State, Zip Code:**

511 East Fourth Street

Shoshone, ID 83352

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<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Summary Statement of Deficiencies</th>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Provider's Plan of Correction</th>
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<tbody>
<tr>
<td>K 161</td>
<td>Continued From page 2</td>
<td>following unsealed penetrations:</td>
<td>K 161</td>
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- **Boiler room ceiling:** an open, twelve inch by twelve inch hole which exposed the floor above and a three inch diameter pipe penetrating the ceiling in which the annular space around the pipe was not sealed.
- **The storage room ceiling:** two pipes approximately two inches in diameter penetrating the ceiling in which the annular space around the pipes was not sealed.

**Actual NFPA standard:**

- **19.1.6 Minimum Construction Requirements.**
  - **19.1.6.1 Health care occupancies shall be limited to the building construction types specified in Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7.** (See 8.2.1.)

  **8.2 Construction and Compartmentation.**
  - **8.2.1 Construction.**
    - **8.2.1.1 Buildings or structures occupied or used in accordance with the individual occupancy chapters, Chapters 11 through 43, shall meet the minimum construction requirements of those chapters.**

**K 200**

**NFPA 101 Means of Egress Requirements - Other**

- **Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 18.2, 19.2**

**K200 SS=F**

**NFPA 101 Means of egress Requirements**

The Maintenance manager will be in-serviced and trained on how to inspect and test fire rated assemblies. To be completed (12/2/16)

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Printed: 11/18/2016

Form Approved OMB No. 0938-0391

Date Survey Completed: 11/09/2016

Page 3 of 19
STANDARD IS NOT MET AS EVIDENCED BY:

Based on record review, observation and interview, the facility failed to ensure that fire rated assemblies were inspected in accordance with NFPA 80. Failure to inspect and test fire rated doors could result in a lack of system performance as designed. This deficient practice affected 29 residents, staff and visitors on the date of the survey. The facility is licensed for 36 SNF/NF beds and had a census of 29 on the day of the survey.

Findings include:

1) During review of provided facility annual inspection records conducted on November 9, 2016 from approximately 9:00 AM to 10:00 AM, no record was available demonstrating an initial inspection and testing of fire rated assemblies had been conducted. When asked about the missing documentation, the Maintenance Supervisor stated he was not aware of this requirement.

2) During the facility tour conducted on November 9, 2016 from approximately 10:00 AM to 12:30 PM, observation of installed doors revealed doors in the following locations were tagged with fire labels:

   - Resident rooms with 45 minute labels
   - Smoke barrier doors with 45 minute labels

Actual NFPA standard:

NFPA 101

19.2 Means of Egress Requirements

All residents, visitors and staff have the potential to be affected by this practice.

Maintenance manager will perform a weekly check for one month
Then monthly for next quarter and then annually

Audits to be reviewed in CQI
Monthly and Administrator will sign all audits and do random checks for compliance

Log of inspections to be kept in Maintenance Log Book.

See Exhibit B
<table>
<thead>
<tr>
<th>ID</th>
<th>Summary Statement of Deficiencies</th>
<th>ID</th>
<th>Provider's Plan of Correction</th>
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<tbody>
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<td>K200</td>
<td>Continued From page 4</td>
<td>K200</td>
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<tr>
<td></td>
<td>7.2.1 Door Openings.</td>
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<td>7.2.1.15 Inspection of Door Openings.</td>
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<td>7.2.1.15.1* Where required by Chapters 11 through 43, the following door assemblies shall be inspected and tested not less than annually in accordance with 7.2.1.15.2 through 7.2.1.15.8:</td>
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<td>(1) Door leaves equipped with panic hardware or fire exit hardware in accordance with 7.2.1.7</td>
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<td>(2) Door assemblies in exit enclosures</td>
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<td>(3) Electrically controlled egress doors</td>
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<td>(4) Door assemblies with special locking arrangements subject to 7.2.1.6</td>
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<td>7.2.1.15.2 Fire-rated door assemblies shall be inspected and tested in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Smoke door assemblies shall be inspected and tested in accordance with NFPA 105, Standard for Smoke Door Assemblies and Other Opening Protectives.</td>
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<td>NFPA 80 5.2* Inspections.</td>
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<td>5.2.1* Fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ.</td>
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<td>K222</td>
<td>NFPA 101 Egress Doors</td>
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<td>Egress Doors</td>
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<td>Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT</td>
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**Bid from Pinacle Technologies LLC for the addition to egress system**, 11/15/16
<table>
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<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<tbody>
<tr>
<td>K 222</td>
<td>Continued From page 5 LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted.</td>
<td>K 222</td>
<td>Signs that are readily visible and durable have been ordered for when placement of addition to Wanderguard is placed. The signage will read: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED 15 SECONDS Signage ordered (12/2/16) All will be assembled by (12/30/16) All residents, visitors and staff have the potential to be affected by this practice. All staff and Maintenance Manager will be in serviced on Life safety Code Citation and deficient practice. Once release is updated staff will be in serviced on the routine for hold and release of egress door. Maintenance Manager will do weekly audit for one month, then monthly there after. Audits to be reviewed in CQI Monthly and Administrator will sign all audits and do random checks for compliance Completion date: February 5th 2017</td>
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<td>ID PREFIX TAG</td>
<td>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
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<td>K 222</td>
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<td>18.2.2.2.4, 19.2.2.2.4</td>
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<td>ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS</td>
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<td>Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4</td>
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<td>This Standard is not met as evidenced by:</td>
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<td>Based on observation, operational testing and interview, the facility failed to ensure that special locking arrangements were in accordance with NFPA 101. Failure to provide delayed egress locking arrangements for magnetically controlled means of egress could hinder the safe evacuation of residents during a fire or other emergency. This deficient practice affected 29 residents, staff and visitors on the date of the survey. The facility is licensed for 36 SNF/NF beds and had a census of 29 on the day of the survey.</td>
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<td>Findings include:</td>
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<td>During the facility tour conducted on November 9, 2016 from approximately 10:00 AM to 11:00 AM, observation of 3 of 3 exit doors revealed the door locking arrangements were magnetically controlled and activated through a Wanderguard system and did not have any signs indicating a delayed egress operation.</td>
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<td>Operational testing of exit doors in the presence of a Wanderguard pendant and magnetic locking arrangement engaged, revealed the doors would not begin the irreversible process and release the doors in the direction of egress. When asked about the locking arrangement, the Maintenance</td>
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**NAME OF PROVIDER OR SUPPLIER:** LINCOLN COUNTY CARE CENTER  
**STREET ADDRESS, CITY, STATE, ZIP CODE:** 511 EAST FOURTH STREET  
**SHOSHONE, ID 83352**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**ID NUMBER:** 135056

**MULTIPLE CONSTRUCTION**

A. BUILDING 01 - ENTIRE BUILDING

B. WING

**DATE SURVEY COMPLETED:** 11/09/2016
Supervisor stated he was not aware of the delayed egress requirement. 

Actual NFPA standard:

7.2.1.6* Special Locking Arrangements.  
7.2.1.6.1 Delayed-Egress Locking Systems.  
7.2.1.6.1.1 Approved, listed, delayed-egress locking systems shall be permitted to be installed on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6 or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 11 through 43, provided that all of the following criteria are met:  
(1) The door leaves shall unlock in the direction of egress upon actuation of one of the following:  
   (a) Approved, supervised automatic sprinkler system in accordance with Section 9.7  
   (b) Not more than one heat detector of an approved, supervised automatic fire detection system in accordance with Section 9.6  
   (c) Not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6  
(2) The door leaves shall unlock in the direction of egress upon loss of power controlling the lock or locking mechanism  
(3)*An irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions:  
   (a) The force shall not be required to exceed 15 lbf (67 N).  
   (b) The force shall not be required to be
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<td>continuously applied for more than 3 seconds.</td>
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<td>(c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening.</td>
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<td>(d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only.</td>
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<td>(4)*A readily visible, durable sign in letters not less than 1 in. (25 mm) high and not less than 1/8 in. (3.2 mm) in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS</td>
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<td>(5) The egress side of doors equipped with delayed-egress locks shall be provided with emergency lighting in accordance with Section 7.8.</td>
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<table>
<thead>
<tr>
<th>K 225</th>
<th>NFPA 101 Stairways and Smokeproof Enclosures</th>
<th>K 225</th>
</tr>
</thead>
<tbody>
<tr>
<td>SS=D</td>
<td>Stairways and Smokeproof Enclosures used as exits are in accordance with 7.2: 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2</td>
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</table>

This Standard is not met as evidenced by:
Based on observation, operational testing and interview, the facility failed to ensure self-closing doors to stairs would fully self-close. Failure to maintain self-closing doors to stairs allowed fire, smoke and dangerous gases to communicate between floors. This deficient practice affected staff and visitors in the main kitchen service corridor on the date of the survey. The facility is licensed for 36 SNF/NF beds and had a census of 29 on the day of the survey.

<table>
<thead>
<tr>
<th>K225 SS=D</th>
<th>NFPA 101 stairways and Smokeproof Enclosures</th>
</tr>
</thead>
<tbody>
<tr>
<td>The facility has audited all self-closing doors and they are in working order.</td>
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On November 9th the Maintenance Manager adjusted the hinges on the door to allow the door to close on its own.

All residents, staff and visitors have the potential to be affected by this practice.
### K 225 Continued From page 9

Findings include:

During the facility tour conducted on November 9, 2016 from approximately 10:00 AM to 12:30 PM, observation and operational testing of the door leading into the basement boiler area from the main floor service corridor revealed the door would not fully self-close when activated. Interview of the Maintenance Supervisor revealed he was not aware this door was not fully self-closing as required.

Actual NFPA standard:

7.2.1.8 Self-Closing Devices.
7.2.1.8.1* A door leaf normally required to be kept closed shall not be secured in the open position at any time and shall be self-closing or automatic-closing in accordance with 7.2.1.8.2, unless otherwise permitted by 7.2.1.8.3.

### K 325 NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR)

Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met:

- * Corridor is at least 6 feet wide
- * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols
- * Dispensers shall have a minimum of 4-foot horizontal spacing
- * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room
- * Storage in a single smoke compartment greater
K 325 Continued From page 10

than 5 gallons complies with NFPA 30
* Dispensers are not installed within 1 inch of an ignition source
* Dispensers over carpeted floors are in sprinklered smoke compartments
* ABHR does not exceed 95 percent alcohol
* Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11)
* ABHR is protected against inappropriate access
18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485
This Standard is not met as evidenced by:
Based on record review, observation and interview, the facility failed to ensure automatically operated Alcohol Based Hand Rub Dispensers (ABHR) were maintained in accordance with NFPA 101. Failure to test and document operation of automatic dispensing ABHR dispensers could result in inadvertently spilling flammable liquids increasing the risk of fires. This deficient practice affected 29 residents, staff and visitors on the date of the survey. The facility is licensed for 36 SNF/NF residents and had a census of 29 on the day of the survey.

Findings include:

1) During the review of facility inspection records conducted on November 9, 2016 from approximately 9:00 AM to 10:00 AM, no records were available indicating inspection and testing of ABHR dispensers was performed when refilling dispensers in accordance with manufacturer's care and use instructions.

2) During the facility tour conducted on November 9, 2016 from approximately 10:00 AM to 12:30 PM, observation of installed ABHR dispensers revealed twelve automatic dispensers installed in the main corridor. When asked about refill testing...
and documentation, the Maintenance Supervisor stated he was not aware that dispensers were required to be tested each time a refill was installed.

Actual NFPA standard:

NFPA 101

19.3.2.6* Alcohol-Based Hand-Rub Dispensers.
Alcohol-based hand-rub dispensers shall be protected in accordance with 8.7.3.1, unless all of the following conditions are met:

(1) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1830 mm).
(2) The maximum individual dispenser fluid capacity shall be as follows:
   (a) 0.32 gal (1.2 L) for dispensers in rooms, corridors, and areas open to corridors
   (b) 0.53 gal (2.0 L) for dispensers in suites of rooms
(3) Where aerosol containers are used, the maximum capacity of the aerosol dispenser shall be 18 oz. (0.51 kg) and shall be limited to Level 1 aerosols as defined in NFPA30B, Code for the Manufacture and Storage of Aerosol Products.
(4) Dispensers shall be separated from each other by horizontal spacing of not less than 48 in (1220 mm).
(5) Not more than an aggregate 10 gal (37.8 L) of alcohol-based hand-rub solution or 1135 oz (32.2 kg) of Level 1 aerosols, or a combination of liquids and Level 1 aerosols not to exceed, in total, the equivalent of 10 gal (37.8 L) or 1135 oz (32.2 kg), shall be in use.
<table>
<thead>
<tr>
<th>ID</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
<th>Completion Date</th>
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<tbody>
<tr>
<td>K 325</td>
<td>Continued From page 12 outside of a storage cabinet in a single smoke compartment, except as otherwise provided in 19.3.2.6(6).&lt;br&gt; (6) One dispenser complying with 19.3.2.6 (2) or (3) per room and located in that room shall not be included in the aggregated quantity addressed in 19.3.2.6(5).&lt;br&gt; (7) Storage of quantities greater than 5 gal (18.9 L) in a single smoke compartment shall meet the requirements of NFPA 30, Flammable and Combustible Liquids Code.&lt;br&gt; (8) Dispensers shall not be installed in the following locations:&lt;br&gt; (a) Above an ignition source within a 1 in. (25 mm) horizontal distance from each side of the ignition source&lt;br&gt; (b) To the side of an ignition source within a 1 in. (25 mm) horizontal distance from the ignition source&lt;br&gt; (c) Beneath an ignition source within a 1 in. (25 mm) vertical distance from the ignition source&lt;br&gt; (9) Dispensers installed directly over carpeted floors shall be permitted only in sprinklered smoke compartments.&lt;br&gt; (10) The alcohol-based hand-rub solution shall not exceed 95 percent alcohol content by volume.&lt;br&gt; (11) Operation of the dispenser shall comply with the following criteria:&lt;br&gt; (a) The dispenser shall not release its contents except when the dispenser is activated, either manually or automatically by touch-free activation.&lt;br&gt; (b) Any activation of the dispenser shall occur only when an object is placed within 4 in. (100 mm) of the sensing device.&lt;br&gt; (c) An object placed within the activation zone and left in place shall not cause more than one activation.&lt;br&gt; (d) The dispenser shall not dispense more solution than the amount required for hand</td>
<td>K 325</td>
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## DEPARTMENT OF HEALTH AND HUMAN SERVICES
### CENTERS FOR MEDICARE & MEDICAID SERVICES

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**PROVIDER/SUPPLIER/CCLA IDENTIFICATION NUMBER:** 135056

**MULTIPLE CONSTRUCTION**
- A. BUILDING 01 - ENTIRE BUILDING
- B. WING

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:** 135056

**NAME OF PROVIDER OR SUPPLIER**
LINCOLN COUNTY CARE CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**
511 EAST FOURTH STREET
SHOSHONE, ID 83352

**DATE SURVEY COMPLETED**
11/09/2016

**ID SUMMARY STATEMENT OF DEFICIENCIES**

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
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<td>K 325</td>
<td>Continued From page 13</td>
<td>K 325</td>
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<td>hygiene consistent with label instructions.</td>
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<td>(e) The dispenser shall be designed, constructed, and operated in a manner that ensures that accidental or malicious activation of the dispensing device is minimized.</td>
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<td>(f) The dispenser shall be tested in accordance with the manufacturer's care and use instructions each time a new refill is installed.</td>
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<tr>
<td>K 353</td>
<td>NFPA 101 Sprinkler System - Maintenance and Testing</td>
<td>K 353</td>
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<tr>
<td>SS=F</td>
<td>Sprinkler System - Maintenance and Testing</td>
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<td></td>
<td>Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</td>
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<td></td>
<td>a) Date sprinkler system last checked</td>
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<td>b) Who provided system test</td>
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<td></td>
<td>c) Water system supply source</td>
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Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.

9.7.5, 9.7.7, 9.7.8, and NFPA 25

This Standard is not met as evidenced by:

Based on observation and interview, the facility failed to ensure fire suppression system pendants were maintained free of obstructions such as paint or corrosion. Failure to maintain fire sprinkler pendants free of obstructions could hinder system performance during a fire event. This deficient practice affected 29 residents, staff and visitors on the date of the survey. The facility is licensed for 36 SNF/NF beds and had a census of 29 residents.

**K353 SS=F**
**NFPA 101 Sprinkler System-Maintenance and testing**

The facility will ensure that the Automatic sprinkler and standpipe system are inspected, and Maintenance Manager is in serviced on proper maintenance of records.

On November 17, 2016 Delta Fire Systems came and replaced sprinkler head in Housekeeping closet and basement storage room door, and completed a quarterly inspection.

See Exhibit F

Staff and Maintenance Manager in serviced on Life safety code citation and deficient practice. All staff is aware to alert maintenance Manager if they see any signs of corrosion or discoloration of sprinkler heads.

Maintenance Manager will do weekly inspection of all sprinkler heads.
### Findings include:

During the facility tour conducted on November 9, 2016 from approximately 10:00 AM to 11:30 AM, observation of the installed fire sprinkler pendants revealed the following:

1. **Housekeeping closet**: Corroded sprinkler
2. **Basement**: Painted sprinkler head over the storage room door

Interview of the Maintenance Supervisor revealed he was not aware of these deficiencies prior to the date of the survey.

**Actual NFPA standard:**

**NFPA 25**

5.2.1 Sprinklers.

5.2.1.1* Sprinklers shall be inspected from the floor level annually.

5.2.1.1.1* Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall).

5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced:
   1. Leakage
   2. Corrosion

See Exhibits F

All audits will be reviewed in CQI meeting and Administrator will sign all audits and do random checks for compliance.
K 353 Continued From page 15
(3) Physical damage
(4) Loss of fluid in the glass bulb heat responsive element
(5)*Loading
(6) Painting unless painted by the sprinkler manufacturer

K 511 NFPA 101 Utilities - Gas and Electric
Utilities - Gas and Electric
Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2

This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure safe electrical installations in accordance with NFPA 70. Utilizing non-grounded multiple plug adapters for electrical connections could result in fires by arcing or electrocution. This deficient practice affected staff and visitors in the main basement boiler area on the date of the survey. The facility is licensed for 36 SNF/NF beds and had a census of 29 on the day of the survey.

Findings include:
During the facility tour conducted on November 9, 2016 from approximately 10:00 AM to 12:30 PM, observation of the Boiler room revealed a fluorescent light fixture plugged into a non-grounded plug adapter and then into a non-grounded plug/light socket adapter. When
<table>
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<tr>
<th>(X1) PROVIDER/SUPPLIER/CLA</th>
<th>(X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER:</th>
<th>(X3) DATE SURVEY COMPLETED</th>
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<td>135056</td>
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**NAME OF PROVIDER OR SUPPLIER**
LINCOLN COUNTY CARE CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**
511 EAST FOURTH STREET
SHOSHONE, ID 83352

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<th>(X5) COMPLETION DATE</th>
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<tr>
<td>K 511</td>
<td>Continued From page 16: asked, the Maintenance Supervisor stated he was not aware of the installation.</td>
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<td>Actual NFPA standard:</td>
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<td>NFPA 70</td>
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<td>110.2 Approval. The conductors and equipment required or permitted by this Code shall be acceptable only if approved.</td>
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<td>Informational Note: See 90.7, Examination of Equipment for Safety, and 110.3, Examination, Identification, Installation, and Use of Equipment. See definitions of Approved, Identified, Labeled, and Listed.</td>
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<td>200.3 Connection to Grounded System. Premises wiring shall not be electrically connected to a supply system unless the latter contains, for any grounded conductor of the interior system, a corresponding conductor that is grounded. For the purpose of this section, electrically connected shall mean connected so as to be capable of carrying current, as distinguished from connection through electromagnetic induction. Exception: Listed utility-interactive inverters identified for use in distributed resource generation systems such as photovoltaic and fuel cell power systems shall be permitted to be connected to premises wiring without a grounded conductor where the connected premises wiring or utility system includes a grounded conductor.</td>
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<tr>
<td>K 916</td>
<td>NFPA 101 Electrical Systems - Essential Electric System</td>
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<td>SS=F</td>
<td>A remote annunciator that is storage battery powered is provided to operate outside of the</td>
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Maintenance Manager will do weekly rounds and audit to ensure that all electrical appliances are plugged into grounded outlets.

Audit will start on 12/2/16

All audits will be reviewed at monthly CQI meetings and Administrator will sign all audits and do random checks for compliance
See Exhibit 6
K 916 Continued From page 17

generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator.

6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99)

This Standard is not met as evidenced by:

Based on observation the facility failed to ensure the Essential Electrical System (EES) was equipped with a remote annunciator in accordance with NFPA 99. Failure to provide a remote annunciator could result in a lack of awareness to system failures during a power outage or other emergency when this system is required. This deficient practice affected 29 residents, staff and visitors on the date of the survey. The facility is licensed for 36 SNF/NF beds and had a census of 29 on the day of the survey.

Findings include:

During the facility tour conducted on November 9, 2016 from approximately 10:00 AM to 12:30 PM, a remote annunciator for the EES was not located at any normally staffed location.

Actual NFPA standard:

NFPA 99
6.4.1.1.17 Alarm Annunciator. A remote annunciator that is storage battery powered shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see 700.12 of NFPA 70, National Electrical Code). The annunciator shall be hard-wired to indicate alarm conditions of the emergency or auxiliary power source as follows:

K 916

K916 NFPA 101 Electrical Systems- Essential Electric System

The facility will ensure that the generator in use for the facility will be equipped with an Annunciator. All residents’ visitors and staff have the potential to be affected by this practice.

On November 22, 2016 Western States assessed and evaluated current generator. The generator, which is in good working order, is of the age that the cost of a new Annunciator exceeds the cost of a replacement.

BRP and Lincoln County commissioner are working as team to look at options for replacing current system. Working on grant and or other programs to assist with the purchase of new system that will accommodate the requirement of an Annunciator that is battery powered that shall be provided to operate outside of the generating room in a location readily observed by operating personal at a regular work station.
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<tr>
<td>K 916</td>
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<td>Continued From page 18</td>
<td>K 916</td>
<td></td>
<td>Meeting to be held on 12/5/16</td>
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<td>(1) Individual visual signals shall indicate the following:</td>
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<td>with BRP Governing Board and</td>
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<td>(a) When the emergency or auxiliary power</td>
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<td>Lincoln county Commissioners</td>
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<td>source is operating to supply power to load</td>
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<td>Lincoln County Care has filed</td>
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<td>(b) When the battery charger is malfunctioning</td>
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<td>for a Temporary Waiver, to give</td>
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<td>(2) Individual visual signals plus a common</td>
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<td>time for the Lincoln County and</td>
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<td>audible signal to warn of an engine-generator</td>
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<td>BRP health Care to acquire</td>
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<td>alarm condition shall indicate the following:</td>
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<td>funding for replacement of</td>
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<td>(a) Low lubricating oil pressure</td>
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<td>current generator.</td>
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<td>(b) Low water temperature (below that required in</td>
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<td>See Exhibit H</td>
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<td>6.4.1.1.11)</td>
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<td>(c) Excessive water temperature</td>
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<td>(d) Low fuel when the main fuel storage tank</td>
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<td>contains less than a 4-hour operating supply</td>
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<td>(e) Overcrank (failed to start)</td>
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<td>(f) Overspeed</td>
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