November 25, 2016

Landon Taylor, Administrator
Life Care Center of Idaho Falls
2725 East 17th Street
Idaho Falls, ID 83406-6601

Provider #: 135091

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Taylor:

On November 15, 2016, a Facility Fire Safety and Construction survey was conducted at Life Care Center of Idaho Falls by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be an isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date to signify when
you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces 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 8, 2016.** Failure to submit an acceptable PoC by **December 8, 2016,** may result in the imposition of civil monetary penalties by **December 28, 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 20, 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 20, 2016.** A change in the seriousness of the deficiencies on **December 20, 2016,** may result in a change in the remedy.
The remedy, which will be recommended if substantial compliance has not been achieved by **December 20, 2016**, includes the following:

Denial of payment for new admissions effective **February 15, 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 15, 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 15, 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 8, 2016. If your request for informal dispute resolution is received after December 8, 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 (Ill) building with partial basement housing hot water heaters. The fully sprinklered structure was built in 1978. A new smoke detection system was installed in 2011. A major renovation was completed in 1998. Currently it is licensed for 109 NF beds.

The following deficiencies were cited at the above facility during the Fire/Life Safety survey conducted on November 15, 2016. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy and 42 CFR 483.70.

The Survey was conducted by:

Linda Chaney
Health Facility Surveyor
Fire Life Safety & Construction
NFPA 101 Egress Doors

K 222

Egress Doors

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 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.

This Plan of Correction is submitted as a required under Federal and State regulations and statutes applicable to long-term care providers. The Plan of Correction does not constitute an admission of liability on part of the facility, and such liability is specifically denied. The submission of this Plan of Correction does not constitute agreement by the facility that the surveyors findings and/or conclusions constitute a deficiency, or that the scope and severity of the deficiencies cited are correctly applied.

Specific Resident

No specific resident was affected by this practice. Egress door in Hallway (3) is repaired and operating within compliance. Exit/egress door in Hallway (4) is repaired and no longer contains a double action lock.

RECEIVED

DEC 12 2016

FACILITY STANDARDS

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.
### K222

**Continued From page 1**

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 fall 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.

18.2.2.2.4, 19.2.2.2.4

**ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS**

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...
K 222 Continued From page 2 detection system and an approved, supervised automatic sprinkler system.
18.2.2.2.4, 19.2.2.2.4
This STANDARD is not met as evidenced by:
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. Failure to maintain means of egress for full instant use could hinder the safe evacuation of residents during an emergency. This deficient practice affected 34 residents, staff and visitors on the date of the survey. The facility is licensed for 109 SNF/NF beds and had a census of 67 on the day of the survey.

Findings include:

1.) During the facility tour on November 15, 2016 from approximately 9:00 AM to 12:00 PM, operational testing of the delayed egress door in the Activity room in Hallway three (3) revealed the door would not operate correctly. When asked, the Maintenance Supervisor stated the facility was unaware that the door was not operational.

2.) During the facility tour on November 15, 2016 from approximately 9:00 AM to 12:00 PM, observation and operational testing of the exit door from the Activity room off of Hallway four (4) revealed the door was equipped with a double action lock, (deadbolt) from the egress side. When asked, the Maintenance Supervisor stated the facility was not aware that deadbolts were not allowed.

Actual NFPA standard:

1.) 7.2.1.5 Locks, Latches, and Alarm Devices.

Monitor

The Maintenance Director or designee will audit compliance for K222 using TELS and/or paper form twice monthly for three months by inspecting 2 egress doors per month to monitor the system compliance beginning 12/5/2016. Maintenance director will bring results of the monitor inspection along with a copy of the routine checks completed by Maintenance staff to the QAPI meeting monthly for review.
# Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CUA Identification Number:** 135091  
**Name of Provider or Supplier:** Life Care Center of Idaho Falls  
**Street Address, City, State, Zip Code:** 2725 East 17th Street, Idaho Falls, ID 83406  
**Date Survey Completed:** 11/15/2016

<table>
<thead>
<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>
<th>Completion Date</th>
</tr>
</thead>
</table>
| K 222         | Continued From page 3  
7.2.1.5.1 Door leaves shall be arranged to be opened readily from the egress side whenever the building is occupied.  
7.2.1.5.3 Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side.  
2.)  
7.2.1.5.10.2 The releasing mechanism shall open the door leaf with not more than one releasing operation, unless otherwise specified in 7.2.1.5.10.3, 7.2.1.5.10.4, or 7.2.1.5.10.6. | K 222         | K 222 | K363  
K363 | Specific Resident  
Corridor rooms 4, 6, 11, 17, 26, 27, 36, 40, 50, and 53 through 57 were identified as being affected by this practice. Corridor doors had smoke stripping applied to all affected doors to reduce the gap between doors and frame to be compliance with K363.  
Other Resident  
All resident doors and office doors were inspected in the facility to identify any other doors that have excessive gaps. Any doors identified were repaired and adjusted as needed to ensure compliance. | 12/3/16 |

**K 363**  
NFPA 101 Corridor - Doors  
Corridor - Doors  
2012 EXISTING  
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. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<table>
<thead>
<tr>
<th>PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER</th>
<th>MULTIPLE CONSTRUCTION</th>
<th>DATE SURVEY COMPLETED</th>
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</thead>
<tbody>
<tr>
<td>135091</td>
<td>A. BUILDING 02 - ENTIRE BUILDING</td>
<td>11/15/2016</td>
</tr>
</tbody>
</table>

### PROVIDER/SUPPLIER IDENTIFICATION NUMBER:

- 135091

### NAME OF PROVIDER OR SUPPLIER:

- LIFE CARE CENTER OF IDAHO FALLS

### STREET ADDRESS, CITY, STATE, ZIP CODE:

- 2725 EAST 17TH STREET, IDAHO FALLS, ID 83406

### SUMMARY STATEMENT OF DEFICIENCIES

**K 363** Continued From page 4

Pulled are permitted. Nonrated protective plates of unlimited height are permitted. 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 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 486

Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.

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 smoke compartments affecting egress and protection in place. This deficient practice has the potential to affect 16 residents, staff, and visitors on the date of survey. The facility is licensed for 109 SNF/NF beds with a census of 67 on the day of survey.

Findings include:

- During the facility tour on November 15, 2016 between 9:00 AM and 12:00 PM, observation and operational testing of multiple corridor doors revealed the doors would not close and seal properly leaving a gap between the door and the door from ranging in size of approximately 1/4 inch to 1/2 inch that would not resist the passage of smoke at the following locations:
  - Room 4, Room 6, Room 11, Room 17, Room 26,

### PROVIDER'S PLAN OF CORRECTION

**K 363**

Systemic Changes

Executive Director educated Maintenance Director and maintenance staff on compliance of K363. Any resident door identified as operating incorrectly will be remedied as needed to assure compliance.

Monitor

Maintenance Director will audit using TELS and/or paper form audit on resident doors for gaps that are not within compliance starting 12/5/16 the Maintenance Director or designee will inspect monthly (5) resident doors to monitor the system for the duration of (3) months. Maintenance director will bring results of the monitor inspection along with a copy of the routine checks completed by Maintenance staff to the QAPI meeting monthly for review.

**Form CMS-2567(02-99) Previous Versions Obsolete Event ID: ZD2B21**

If continuation sheet Page 5 of 8
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 363</td>
<td>Continued From page 5 Room 27, Room 36, Room 40, Room 50, and Rooms 53 through 57. When asked, the Maintenance Supervisor stated the facility was unaware of the gaps between the doors and the door frames. Actual NFPA Standards: 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 doors constructed to resist the passage of smoke and shall be constructed of materials such as the following: (1) 13/4 in. (44 mm) thick, solid-bonded core wood (2) Material that resists fire for a minimum of 20 minutes</td>
<td>K 363</td>
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<tr>
<td>K 511 SS=D</td>
<td>NFPA 101 Utilities - Gas and Electric</td>
<td>K 511</td>
<td>Specific Resident There were two specific residents identified as being affected by this practice. The RPTs located in Director of Nursing office have been removed. The RPTs located in resident room (24) have been removed to be within compliance. The RPTs located in MDS office have been removed.</td>
<td>12/9/16</td>
<td></td>
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This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that electrical installations were
Continued From page 6

in accordance with NFPA 70. Failure to ensure proper electrical installations could result in electrocution or fire. This deficient practice affected 2 residents, staff and visitors on the date of the survey. The facility is licensed for 109 SNF/NF beds and had a census of 67 on the day of the survey.

Findings include:

During the facility tour on November 15, 2016 from approximately 9:00 AM to 12:00 PM, observation of the following areas revealed RPTs (Relocatable Power Taps) were being used as a substitute for fixed wiring:

1.) Director of Nursing Office had a microwave and a refrigerator plugged in to an RPT.
2.) Resident room 24 had two (2) oxygen concentrators a medical bed and a refrigerator plugged in to RPTs.
3.) MDS Coordinator Office had a refrigerator plugged in to an RPT.

When asked, the Maintenance Supervisor stated the facility was unaware that medical equipment and small appliances could not use RPTs as fixed wiring.

Actual NFPA standard:

NFPA 70
400.8 Uses Not Permitted.
Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following:
(1) As a substitute for the fixed wiring of a structure
(2) Where run through holes in walls, structural...
SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION

K 511 Continued From page 7 ceilings, suspended ceilings, dropped ceilings, or floors
(3) Where run through doorways, windows, or similar openings
(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 368.8.
(5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings
(6) Where installed in raceways, except as otherwise permitted in this Code

K 511 Monitor
Maintenance Director will audit using TELS and/or paper form audit to identify correct usage of RPTs to ensure compliance. Starting 12/5/16 the Maintenance Director or designee will inspect monthly (5) resident rooms and (2) offices to monitor the system for the duration of (3) months. Maintenance director will bring results of the monitor inspection along with a copy of the routine checks completed by Maintenance staff to the QAPI meeting monthly for review.