April 18, 2017

Steve Gannon, Administrator
Quinn Meadows Rehabilitation & Care Center
1033 West Quinn Road
Pocatello, ID 83202-2425

Provider #: 135136

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Gannon:

On April 4, 2017, a Facility Fire Safety and Construction survey was conducted at Quinn Meadows Rehabilitation & 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 May 1, 2017. Failure to submit an acceptable PoC by May 1, 2017, may result in the imposition of civil monetary penalties by May 21, 2017.

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 May 9, 2017, (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 May 9, 2017. A change in the seriousness of the deficiencies on May 9, 2017, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by May 9, 2017, includes the following:
Denial of payment for new admissions effective **July 4, 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 **October 4, 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 **April 4, 2017**, 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 May 1, 2017. If your request for informal dispute resolution is received after May 1, 2017, 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/j
Enclosures
**K 000 INITIAL COMMENTS**

The facility is an approximately 26,000 square foot Type V (111) construction, subdivided into two smoke compartments, with an attached but two-hour separated Physical Therapy section. The building is fully sprinklered and equipped with a manual fire alarm system. Emergency power is provided by an onsite generator system. The facility is currently licensed for 41 beds.

The following deficiencies were cited during the annual fire safety survey conducted on April 4, 2017. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancies, in accordance with 42 CFR, 483.70.

The survey was conducted by:

Sam Burbank  
Health Facility Surveyor  
Facility Fire Safety & Construction

**K 211 SS=F**  
Means of Egress - General  
NFPA 101 Means of Egress - General

Means of Egress - General  
Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11, 18.2.1.1, 19.2.1.1, 7.1.10.1

This STANDARD is not met as evidenced by:  
Based on record review and observation, the facility failed to ensure that rated assemblies were inspected annually in accordance with either NFPA 80 or NFPA 105, as applicable. Failure to inspect and test rated assemblies could result in

**K 211 K-241**  
NFPA 105 Means of Egress - General  
NFPA 80 Means of Egress - General

Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:

Inspection and testing of fire rated assemblies is scheduled for Monday 5/1/2017 and will be scheduled annually thereafter.

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**LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE**

**TITLE**

**DATE**

04/28/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>PROVIDER/SUPPLIER/CIA IDENTIFICATION NUMBER:</th>
<th>A. BUILDING 01 - QUINN MEADOWS</th>
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<tbody>
<tr>
<td>135136</td>
<td>B. WING</td>
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<tr>
<th>PROVIDER/SUPPLIER</th>
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<tbody>
<tr>
<td>QUINN MEADOWS REHABILITATION &amp; CARE CENTER</td>
<td>1033 WEST QUINN ROAD POCATELLO, ID 83202</td>
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<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>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>
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<tr>
<td>K 211</td>
<td>Continued From page 1</td>
<td>a lack of system performance as designed. This deficient practice affected 31 residents, staff and visitors on the date of the survey. The facility is licensed for 41 SNF/NF beds and had a census of 31 on the day of the survey. Findings include: 1) During review of provided facility annual inspection records conducted on April 4, 2017 from approximately 9:00 AM to 10:00 AM, no record was provided demonstrating an initial or annual inspection and testing of fire rated assemblies had been conducted. 2) During the facility tour conducted on April 4, 2017 from approximately 10:00 AM to 2:30 PM, observation of installed doors revealed both doors and frames throughout the facility were tagged with either fire or fire/smoke labels, ranging from twenty (20) minutes to one (1) hour, resistive rating. Actual NFPA standard: NFPA 101 19.2 Means of Egress Requirements 19.2.2.2 Doors. 19.2.2.2.1 Doors complying with 7.2.1 shall be permitted. 7.2.1 Door Openings. 7.2.1.15 Inspection of Door Openings. 7.2.1.15.4 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: (1) Door leaves equipped with panic hardware or</td>
<td>K 211</td>
<td>cont...</td>
<td>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following: All residents may have the potential to be affected by this deficiency; hence by 4/28/2017 the Administrator or designee will perform a one time observation to ensure that all fire/smoke doors in the facility have a fire rating assembly tag on the door/door frame to ensure they are included in the annual inspection and testing. Measures that will be put into place or systemic changes that will be made to ensure that the deficient practice does not recur includes the following: A 1:1 in-service will be provided to the maintenance director to ensure fire rating assembly inspection and testing is done annually on all fire rated assembly doors in the facility. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: The Administrator or designee will: 1) do a visual observation of 3 random fire/smoke doors in the facility to ensure that they have rate assembly tags;</td>
<td>04/04/2017</td>
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<td>ID</td>
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<td>SUMMARY STATEMENT OF DEFICIENCIES</td>
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<td>K 211</td>
<td>cont.</td>
<td>From page 2 fire exit hardware in accordance with 7.2.1.7 (2) Door assemblies in exit enclosures (3) Electrically controlled egress doors (4) Door assemblies with special locking arrangements subject to 7.2.1.6 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. NFPA 80 5.2 Inspections. 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. NFPA 105 5.2 Specific Requirements. 5.2.1.* Inspections. 5.2.1.1 Smoke door assemblies shall be inspected annually. 5.2.1.2 Doors shall be operated to confirm full closure. 5.2.1.3 Hardware and gaskets shall be inspected annually, and any parts found to be damaged or inoperative shall be replaced. K 223 Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</td>
<td>K 211</td>
<td>cont.</td>
<td>2) do a check to ensure that annual inspection and testing of fire rated assemblies has been conducted. Monitoring will start on 5/4/2017. This will be done weekly x 4, the every 2 weeks x 4, then monthly x 3. The administrator or designee will present to the quarterly QA&amp;A committee the findings and/or corrective actions taken. Compliance, continuation/discontinuation of monitoring will be discussed during the QA&amp;A committee quarterly meeting.</td>
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<tr>
<td>K 223</td>
<td>SS=F</td>
<td>Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release</td>
<td>K 223</td>
<td>5/2/17</td>
<td>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</td>
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## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

### ID PREFIX TAG

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<thead>
<tr>
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<th>COMPLETION DATE</th>
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<tbody>
<tr>
<td>K 223</td>
<td>Continued From page 3</td>
<td>K 223 cont...</td>
<td>The rubber door chock used to hold open the door in the two-hour separation from the nursing home to the Physical Therapy wing has been removed and discarded to allow the self-closing door to automatically close and not be held open by a means other than those interconnected to the fire alarm system.</td>
<td>4/28/2017</td>
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<td>device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of:</td>
<td></td>
<td>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:</td>
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<td></td>
<td>* Required manual fire alarm system; and</td>
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<td>All residents may have the potential to be affected by this deficiency; hence by 4/28/2017 the Administrator or designee will perform a one time observation to ensure that any self-closing doors which are a part of a fire/smoke barrier in the facility are not held open by a rubber door chock to allow the self-closing door to automatically close and not be held open by a means other than those interconnected to the fire alarm system.</td>
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<td>* Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</td>
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<td>Measures that will be put into place or systemic changes that will be made to ensure that the deficient practice does not recur includes the following:</td>
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<td>* Automatic sprinkler system, if installed; and</td>
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<td>* Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This STANDARD is not met as evidenced by:</td>
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<td>Based on observation and interview, the facility failed to ensure self-closing doors in smoke barriers were not held open by a means other than those interconnected to the fire alarm system. Obstructing smoke barrier doors from self-closing as designed could allow smoke and dangerous gases to pass between smoke compartments during a fire. This deficient practice affected 23 residents, staff and visitors on the date of the survey. The facility is licensed for 41 SNF/NF beds and had a census of 31 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 April 4, 2017 from approximately 1:00 PM to 2:30 PM, observation of the door in the two-hour separation from the nursing home to the Physical Therapy wing revealed the self-closing door was held open by a rubber door chock. When asked why the door was held open in this fashion, the Therapy staff present stated the door was blocked open to prevent the door from self-closing on residents entering for therapy treatment.</td>
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<td>Actual NFPA standard:</td>
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### NAME OF PROVIDER OR SUPPLIER

QUINN MEADOWS REHABILITATION & CARE CENTER

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

1033 WEST QUINN ROAD
POCATELLO, ID 83202

### PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

The rubber door chock used to hold open the door in the two-hour separation from the nursing home to the Physical Therapy wing has been removed and discarded to allow the self-closing door to automatically close and not be held open by a means other than those interconnected to the fire alarm system.

Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:

All residents may have the potential to be affected by this deficiency; hence by 4/28/2017 the Administrator or designee will perform a one time observation to ensure that any self-closing doors which are a part of a fire/smoke barrier in the facility are not held open by a rubber door chock to allow the self-closing door to automatically close and not be held open by a means other than those interconnected to the fire alarm system.

Measures that will be put into place or systemic changes that will be made to ensure that the deficient practice does not recur includes the following:
| **K 223** | **K 223 cont...** |
| ** Continued From page 4** | **To ensure that the deficient practice does not recur, starting by 4/28/2017 the Administrator or designee will provide an all staff in-service to emphasize the importance of ensuring that any self-closing doors which are a part of a fire/smoke barrier in the facility are not held open by a rubber door chock to allow the self-closing door to automatically close and not be held open by a means other than those interconnected to the fire alarm system.** |
| **19.2.2.2.7** Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier, or hazardous area enclosure shall be permitted to be held open only by an automatic release device that complies with 7.2.1.8.2. The automatic sprinkler system, if provided, and the fire alarm system, and the systems required by 7.2.1.8.2, shall be arranged to initiate the closing action of all such doors throughout the smoke compartment or throughout the entire facility. | **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** |
| | **Monitoring will be done through:** |
| | **The Administrator or designee will do a visual observation of self-closing doors which are a part of a fire/smoke barrier in the facility to ensure they are not held open by a rubber door chock to allow the self-closing door to automatically close and not be held open by a means other than those interconnected to the fire alarm system.** |
| | **Monitoring will start on 5/4/2017.** |
| | **This will be done weekly x 4, the every 2 weeks x 4, then monthly x 3.** |
| | **The administrator or designee will present to the quarterly QA&A committee the findings and/or corrective actions taken.** |
| | **Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A committee quarterly meeting.** |

**Findings include:**

During the facility tour conducted on April 4, 2017 from approximately 12:30 PM to 1:30 PM, observation of the south end of the 200 hall revealed the following:

- Dead-End Corridors and Common Path of Travel 2012 EXISTING
- Dead-end corridors shall not exceed 30 feet. Existing dead-end corridors greater than 30 feet shall be permitted to be continued to be used if it is impractical and unfeasible to alter them.

**19.2.5.2 This STANDARD is not met as evidenced by:**

- Based on observation and interview, the facility failed to ensure means of egress did not terminate in a dead-end corridor. Creating dead-end corridors confuses residents and hinders egress during fires or other emergencies. This deficient practice affected 19 residents, staff and visitors on the date of the survey. The facility is licensed for 41 SNF/NF beds and had a census of 31 on the day of the survey.

- How the corrective action(s) will be monitored to ensure the deficient practice will not recur:

- Monitoring will be done through:

- The Administrator or designee will do a visual observation of self-closing doors which are a part of a fire/smoke barrier in the facility to ensure they are not held open by a rubber door chock to allow the self-closing door to automatically close and not be held open by a means other than those interconnected to the fire alarm system.


- This will be done weekly x 4, the every 2 weeks x 4, then monthly x 3.

- The administrator or designee will present to the quarterly QA&A committee the findings and/or corrective actions taken.

- Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A committee quarterly meeting.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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**NAME OF PROVIDER OR SUPPLIER**

QUINN MEADOWS REHABILITATION & CARE CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1033 WEST QUINN ROAD
POCATELLO, ID 83202

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**SUMMARY STATEMENT OF DEFICIENCIES**

**EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION**

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<td>K 251</td>
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<td>From page 5</td>
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The door leading to the exterior of the building was equipped with a panic bar that had been disabled from operation with a label reading: "Not an Exit" installed on the glass. Directly to the left of this door a fire alarm pull station was installed in accordance with required installations for manual activation within 60 inches of exit doorways as outlined in NFPA 72. An internally illuminated exit sign was installed above the door and turned to face the south wall, rendering clear identification of the exit from resident rooms ineffectual. Length of the hallway from the intersection point of the main Nurse's station to the exit was approximately sixty-five (65) feet.

When asked about the components identified which had created the dead-end corridor, the Administrator stated this condition had existed since he started at the facility and believed had been approved prior to the survey.

Actual NFPA standard:

19.2.5.2* Dead-End Corridors. Existing dead-end corridors not exceeding 30 ft (9.1 m) shall be permitted. Existing dead-end corridors exceeding 30 ft (9.1 m) shall be permitted to continue in use if it is impractical and unfeasible to alter them.

**IDENTIFICATION OF OTHER RESIDENTS HAVING THE SAME POTENTIAL TO BE AFFECTED BY THE SAME PRACTICE AND WHAT CORRECTIVE ACTION(S) TAKEN INCLUDES THE FOLLOWING:**

All residents may have the potential to be affected by this deficiency; hence by 4/28/2017 the Administrator or designee will perform a one time observation to ensure that all means of egress to the exterior of the building do not terminate in a dead-end corridor.

**MEASURES THAT WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES THAT WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR INCLUDES THE FOLLOWING:**

If continualron sheet Page 6 of 21
K 325 Continued From page 6

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 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 activated 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 excessive flammable liquids being dispensed, increasing the risk of fires. This deficient practice affected 31 residents, staff and visitors on the day of the survey. The facility is licensed for 41 SNF/NF residents and had a census of 31 on the day of the survey.

Findings include:

1) During the review of facility inspection records conducted on April 4, 2017 from approximately 8:00 AM to 10:30 AM, no records were available

To ensure that the deficient practice does not recur, starting on 4/28/2017 the Administrator or designee will:

1) do a weekly check to ensure that the door leading to the exterior of the building on the 200 hall is equipped with a working panic bar;

2) do a weekly check to ensure that the door leading to the exterior of the building on the 200 hall is not labeled ‘Not an Exit’;

3) do a weekly check to ensure that the internally illuminated exit sign above the door leading to the exterior of the building on the 200 hall is facing the correct direction to enable clear identification of an emergency exit;

4) do a weekly check of all means of egress to ensure they do not terminate in a dead-end corridor.

Monitoring will be done through:

The Administrator or designee will do a visual observation of 3 random means of egress to the exterior of the facility to ensure they do not terminate in a dead-end corridor.

Monitoring will start on 5/4/2017. This will be done weekly x 4, the every 2 weeks x 4, then monthly x 3.

The administrator or designee will present to the quarterly QA&A committee the findings and/or corrective actions taken. Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A committee quarterly meeting.
**K 325** Continued From page 7

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 April 4, 2017 from approximately 10:00 AM to 2:30 PM, observation of installed ABHR dispensers revealed automatic dispensers were installed throughout the facility.

When asked about refill testing and documentation, the Housekeeping staff stated they believed the Maintenance Supervisor was the person responsible for refilling the dispensers. Further inquiry of the Maintenance Supervisor during a telephone interview, he stated the Housekeeping staff refilled the dispensers, but was not aware of any testing requirement.

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

K 325

Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:

A maintenance record has been created to document that ABHR dispensers were inspected and tested each time they are refilled.

Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:

All residents may have the potential to be affected by this deficiency; hence by 4/28/2017 the Administrator or designee will perform a one time observation to ensure that all Alcohol Based Hand Rub Dispensers in the facility are identified to ensure that documentation of inspection and testing takes place each time dispensers are refilled.

Measures that will be put into place or systemic changes that will be made to ensure that the deficient practice does not recur includes the following:

To ensure that the deficient practice does not recur, starting on 4/28/2017 the Administrator or designee will provide an in-service to all housekeeping/maintenance staff to understand the importance of ensuring that they inspect, test and record proper operation of ABHR dispensers upon each refilling.
K 325 Continued

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 NFPA 308, 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 outside of a storage cabinet in a single smoke compartment, except as otherwise provided in 19.3.2.6(5).

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).

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.

8) Dispensers shall not be installed in the following locations:

(a) Above an ignition source within a 1 in. (25 mm) horizontal distance from each side of the ignition source

(b) To the side of an ignition source within a 1 in. (25 mm) horizontal distance from the ignition source

(c) Beneath an ignition source within a 1 in. (25 mm) vertical distance from the ignition source

9) Dispensers installed directly over carpeted floors shall be permitted only in sprinklered

How the corrective action(s) will be monitored to ensure the deficient practice will not recur:

Monitoring will be done through:

The Administrator or designee will:

1) do a visual observation of 3 random ABHD dispensers to ensure they operate correctly;

2) do a random check of the documentation regarding ABHR dispensers to ensure they are being inspected and tested when they are being refilled.

Monitoring will start on 5/4/2017.

This will be done weekly x 4, the every 2 weeks x 4, then monthly x 3.

The administrator or designee will present to the quarterly QA&A committee the findings and/or corrective actions taken.

Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A committee quarterly meeting.
K 325  Continued From page 9

smoke compartments.
(10) The alcohol-based hand-rub solution shall not exceed 95 percent alcohol content by volume.
(11) Operation of the dispenser shall comply with the following criteria:
(a) The dispenser shall not release its contents except when the dispenser is activated, either manually or automatically by touch-free activation.
(b) Any activation of the dispenser shall occur only when an object is placed within 4 in. (100 mm) of the sensing device.
(c) An object placed within the activation zone and left in place shall not cause more than one activation.
(d) The dispenser shall not dispense more solution than the amount required for hand hygiene consistent with label instructions.
(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.
(f) The dispenser shall be tested in accordance with the manufacturer’s care and use instructions each time a new refill is installed.

K 353  Sprinkler System - Maintenance and Testing

Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:

The 2 corroded fire suppression system pendants above the dishwashing area in the main Kitchen are scheduled to be replaced on Tuesday May 2, 2017.

NFPA 101 Sprinkler System - Maintenance and Testing
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.

a) Date sprinkler system last checked
K 353 Continued From page 10

b) Who provided system test

c) Water system supply source

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, 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 located in harsh environments which increase the potential for corrosion, could hinder system performance during a fire event. This deficient practice affected staff and vendors of the main Kitchen on the day of the survey. The facility is licensed for 41 SNF/NF beds and had a census of 31 on the day of the survey.

Findings include:

During the facility tour conducted on April 4, 2017 from approximately 1:00 PM to 2:30 PM, observation of installed fire sprinkler pendants revealed two corroded sprinkler pendants above the dishwashing area in the main Kitchen.

Actual NFPA standard:

NFPA 25

5.2.1 Sprinklers.

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

Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:

This deficiency is an isolated deficiency as reflected in the Statement of deficiencies form CMS-2567.

However, all residents may have the potential to be affected by this deficiency; hence by 4/28/2017 the Administrator or designee will perform a one time observation to ensure that all fire suppression system pendants in the facility are free from corrosion.

Measures that will be put into place or systemic changes that will be made to ensure that the deficient practice does not recur includes the following:

A 1:1 in-service will be provided to the Maintenance Director to implement a monthly inspection of the fire suppression pendants above the dishwashing area in the main Kitchen to ensure they are free of corrosion.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur:

The Administrator or designee will do a visual observation of 3 random fire suppression system pendants to ensure they are free of corrosion.
<table>
<thead>
<tr>
<th>(x1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:</th>
<th>135136</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME OF PROVIDER OR SUPPLIER</td>
<td>QUINN MEADOWS REHABILITATION &amp; CARE CENTER</td>
</tr>
<tr>
<td>STREET ADDRESS, CITY, STATE, ZIP CODE</td>
<td>1033 WEST QUINN ROAD POCATELLO, ID 83202</td>
</tr>
<tr>
<td>EXISTING Smoke Barrie</td>
<td></td>
</tr>
<tr>
<td>Construction 2012</td>
<td></td>
</tr>
<tr>
<td>Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for</td>
<td></td>
</tr>
<tr>
<td>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</td>
<td></td>
</tr>
</tbody>
</table>
| The annular spaces around the bundled cabling and the walls of the conduits in the data room on the 100 hall which houses data cable bundles entering the attic space above have been sealed to prevent the passage of fire and smoke between compartments in the event of a fire. |}

<table>
<thead>
<tr>
<th>K 353</th>
<th>Continued From page 11</th>
</tr>
</thead>
<tbody>
<tr>
<td>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, pendant, or sidewall).</td>
<td></td>
</tr>
<tr>
<td>5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced:</td>
<td></td>
</tr>
<tr>
<td>(1) Leakage</td>
<td></td>
</tr>
<tr>
<td>(2) Corrosion</td>
<td></td>
</tr>
<tr>
<td>(3) Physical damage</td>
<td></td>
</tr>
<tr>
<td>(4) Loss of fluid in the glass bulb heat responsive element</td>
<td></td>
</tr>
<tr>
<td>(5)*Loading</td>
<td></td>
</tr>
<tr>
<td>(6) Painting unless painted by the sprinkler manufacturer</td>
<td></td>
</tr>
<tr>
<td>5.3.1.1.2* Where sprinklers are subjected to harsh environments including corrosive atmospheres and corrosive water supplies, on a 5-year basis, either sprinklers shall be replaced or representative sprinkler samples shall be tested.</td>
<td></td>
</tr>
<tr>
<td>NFPA 101 Subdivision of Building Spaces - Smoke Barrie</td>
<td></td>
</tr>
<tr>
<td>Subdivision of Building Spaces - Smoke Barrier Construction 2012</td>
<td></td>
</tr>
<tr>
<td>Monitoring will start on 5/4/2017.</td>
<td></td>
</tr>
<tr>
<td>This will be done weekly x 4, the every 2 weeks x 4, then monthly x 3.</td>
<td></td>
</tr>
<tr>
<td>The administrator or designee will present to the quarterly QA&amp;A committee the findings and/or corrective actions taken.</td>
<td></td>
</tr>
<tr>
<td>Compliance, continuation/discontinuation of monitoring will be discussed during the QA&amp;A committee quarterly meeting.</td>
<td></td>
</tr>
<tr>
<td>K 353 cont...</td>
<td></td>
</tr>
<tr>
<td>K 372</td>
<td></td>
</tr>
<tr>
<td>Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:</td>
<td></td>
</tr>
<tr>
<td>The annular spaces around the bundled cabling and the walls of the conduits in the data room on the 100 hall which houses data cable bundles entering the attic space above have been sealed to prevent the passage of fire and smoke between compartments in the event of a fire.</td>
<td></td>
</tr>
</tbody>
</table>
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

#### (X1) PROVIDER/SUPPLIER/CUAA IDENTIFICATION NUMBER:

135136

#### (X2) MULTIPLE CONSTRUCTION

A. BUILDING D1 - QUINN MEADOWS

#### (X3) DATE SURVEY COMPLETED

04/04/2017

#### (X4) ID PREFIX TAG

K 372

#### SUMMARY STATEMENT OF DEFICIENCIES

(Each deficiency must be preceded by full regulatory or LSC identifying information)

<table>
<thead>
<tr>
<th>Identifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 372</td>
<td>Continued from page 12</td>
</tr>
<tr>
<td></td>
<td>Smoke compartments adjacent to the smoke barrier.</td>
</tr>
<tr>
<td></td>
<td>19.3.7.3, 8.6.7.1(1)</td>
</tr>
<tr>
<td></td>
<td>Describe any mechanical smoke control system in REMARKS.</td>
</tr>
<tr>
<td></td>
<td>This STANDARD is not met as evidenced by:</td>
</tr>
<tr>
<td></td>
<td>Based on observation, the facility failed to ensure the fire and smoke resistive properties of the structure were maintained. Failure to seal penetrations in fire/smoke barriers could allow fires and smoke to pass between compartments.</td>
</tr>
<tr>
<td></td>
<td>This deficient practice affected 12 residents, staff and visitors on the date of the survey. The facility is licensed for 41 SNF/NF beds and had a census of 31 on the day of the survey.</td>
</tr>
<tr>
<td></td>
<td>Findings include:</td>
</tr>
<tr>
<td></td>
<td>During the facility tour conducted on April 4, 2017 from approximately 10:30 AM to 11:00 AM, observation of the data room in the 100 hall revealed conduits which housed data cable bundles, entering the attic space above. Further observation revealed the annular spaces around the bundled cabling and the walls of these conduits were unsealed. These unsealed conduits ranged in the following sizes and quantities:</td>
</tr>
<tr>
<td></td>
<td>Eight (8) conduits approximately 2-1/2 inches in diameter</td>
</tr>
<tr>
<td></td>
<td>One (1) conduit approximately 4 inches in diameter</td>
</tr>
<tr>
<td></td>
<td>One (1) conduit approximately 3/4 inch in diameter</td>
</tr>
<tr>
<td></td>
<td>Actual NFPA standard:</td>
</tr>
<tr>
<td></td>
<td>8.5.6 Penetrations.</td>
</tr>
</tbody>
</table>

#### PROVIDER'S PLAN OF CORRECTION

(Each corrective action should be cross-referenced to the appropriate deficiency)

<table>
<thead>
<tr>
<th>Identifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 372</td>
<td>This deficiency is an isolated deficiency as reflected in the Statement of deficiencies - form CMS-2567.</td>
</tr>
<tr>
<td></td>
<td>However, all residents may have the potential to be affected by this deficiency; hence by 4/28/2017 the Administrator or designee will perform a one time observation of all rooms in the facility to ensure that any other penetrations of the fire/smoke barriers into the attic space above are appropriately sealed.</td>
</tr>
<tr>
<td></td>
<td>Measures that will be put into place or systemic changes that will be made to ensure that the deficient practice does not recur includes the following:</td>
</tr>
<tr>
<td></td>
<td>To ensure that the deficient practice does not recur, starting on 4/28/2017 the Administrator or designee will do a weekly check of the data room to ensure that any new penetrations in the fire/smoke barrier into the attic above are sealed appropriately.</td>
</tr>
<tr>
<td></td>
<td>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</td>
</tr>
<tr>
<td></td>
<td>Monitoring will be done through:</td>
</tr>
<tr>
<td></td>
<td>The Administrator or designee will do a visual observation of 3 random rooms in the facility to ensure that any penetrations of the fire/smoke barrier into the attic are sealed appropriately.</td>
</tr>
</tbody>
</table>
| K 372 | Continued From page 13
|       | 8.5.6.3 Where a smoke barrier is also constructed as a fire barrier, the penetrations shall be protected in accordance with the requirements of 8.3.5 to limit the spread of fire for a time period equal to the fire resistance rating of the assembly and 8.5.6 to restrict the transfer of smoke, unless the requirements of 8.5.6.4 are met.

8.3.5.1 Firestop Systems and Devices Required. Penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device. The firestop system or device shall be tested in accordance with ASTM E 814, Standard Test Method for Fire Tests of Through Penetration Fire Stops, or ANSI/UL 1479, Standard for Fire Tests of Through-Penetration Firestops, at a minimum positive pressure differential of 0.01 in. water column (2.5 N/m²) between the exposed and the unexposed surface of the test assembly.

K 374 | SS=F Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window

K 372 cont...

Monitoring will start on 5/4/2017.

This will be done weekly x 4, the every 2 weeks x 4, then monthly x 3.

The administrator or designee will present to the quarterly QA&A committee the findings and/or corrective actions taken.

Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A committee quarterly meeting.

K 374 | Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:

The 2 inch section of the smoke seal gasket for the smoke barrier doors on the 100 hall was re-attached to the header portion of the door assembly eliminating the ¼ inch gap between the leading edge of the door and the face of the frame and restoring the integrity of the smoke barrier seal.

5/2/17
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:** 135136

**State:** ID

**Name of Provider or Supplier:** Quinn Meadows Rehabilitation & Care Center

**Street Address, City, State, Zip Code:** 1033 West Quinn Road, Pocatello, ID 83202

**ID Prefix Tag:** K 374

<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>Provider's Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 374</td>
<td>Continued from page 14. Assembles per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This STANDARD is not met as evidenced by: Based on observation and operational testing, the facility failed to ensure smoke barrier doors would resist the passage of smoke. Failure to maintain smoke seals on smoke barrier doors could allow smoke and dangerous gases to pass between smoke compartments, hindering egress of residents during a fire. This deficient practice affected 31 residents, staff and visitors on the date of the survey. The facility is licensed for 41 SNF/NF beds and had a census of 31 on the day of the survey. Findings include: During the facility tour conducted on April 4, 2017 from approximately 10:30 AM to 11:00 AM, observation and operational testing of the smoke barrier doors in the 100 hall revealed the smoke seal gasket for the doors was falling away from the header portion of the assembly, leaving a gap of approximately 1/4 inch between the leading edge of the door and the face of the frame, approximately two (2) inches in length. Actual NFPA standard: NFPA 101 8.5.4.1* Doors in smoke barriers shall close the opening, leaving only the minimum clearance necessary for proper operation, and shall be...</td>
<td>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following: All residents may have the potential to be affected by this deficiency; hence by 4/28/2017 the Administrator or designee will perform a one-time observation to ensure that gaskets for smoke barrier doors are not falling away from the header portion of the assembly. Measures that will be put into place or systemic changes that will be made to ensure that the deficient practice does not recur includes the following: To ensure that the deficient practice does not recur, starting on 4/28/2017 the Administrator or designee will do a weekly check of the 100 hall smoke barrier doors to ensure that the smoke seal gasket for the doors is attached appropriately. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Monitoring will be done through: The Administrator or designee will do a visual observation to ensure that smoke seal gasket(s) for the smoke barrier door(s) is attached appropriately.</td>
<td>04/04/2017</td>
</tr>
</tbody>
</table>
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
<th>(X3) DATE SURVEY COMPLETED</th>
</tr>
</thead>
<tbody>
<tr>
<td>135136</td>
<td>A. BUILDING 01 - QUINN MEADOWS</td>
<td>04/04/2017</td>
</tr>
</tbody>
</table>

**NAME OF PROVIDER OR SUPPLIER**

QUINN MEADOWS REHABILITATION & CARE CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1033 WEST QUINN ROAD

POCATELLO, ID 83202

<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 374</td>
<td>Continued From page 15 without louvers or grilles. The clearance under the bottom of a new door shall be a maximum of 3.4 in. (19 mm). 8.5.4.4* Doors in smoke barriers shall be self-closing or automatic-closing in accordance with 7.2.1.18 and shall comply with the provisions of 7.2.1. 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. NFPA 105 Chapter 5 Maintenance 5.2.1.3 Hardware and gaskets shall be inspected annually, and any parts found to be damaged or inoperative shall be replaced.</td>
<td>5/2/17</td>
</tr>
<tr>
<td>K 511</td>
<td>SS=D 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</td>
<td>5/2/17</td>
</tr>
</tbody>
</table>

**K 374 cont...**

Monitoring will start on 5/4/2017.

This will be done weekly x 4, the every 2 weeks x 4, then monthly x 3.

The administrator or designee will present to the quarterly QA&A committee the findings and/or corrective actions taken.

Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A committee quarterly meeting.

**K 511**

Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:

The portable air compressor has been unplugged from the relocatable power tap and plugged into a direct electrical outlet. The portable air compressor plug cord has been secured to ensure it is not plugged into a relocatable power tap and can only reach the direct electrical outlet for use.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:**

- 135136

**NAME OF PROVIDER OR SUPPLIER:**

QUINN MEADOWS REHABILITATION & CARE CENTER

**ID PREFIX TAG**

**SUMMARY STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

- K 511

**ID PREFIX TAG**

**PROVIDER'S PLAN OF CORRECTION**

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

- K 511

Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following:

- This deficiency is an isolated deficiency as reflected in the Statement of deficiencies - form CMS-2567.

Measures that will be put into place or systemic changes that will be made to ensure that the deficient practice does not recur includes the following:

- This deficiency is an isolated deficiency as reflected in the Statement of deficiencies - form CMS-2567.

However, all residents may have the potential to be affected by this deficiency; hence by 4/28/2017 the Administrator or designee will provide an all-staff in-service to ensure staff are aware that the facility portable air compressor must be plugged in to a direct outlet and not plugged in to a relocatable power tap (power strip).

How the corrective action(s) will be monitored to ensure the deficient practice will not recur:

- Monitoring will be done through:

---

**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. Operation of portable air compressors by substituting a flexible electrical cord or cable such as a relocatable power tap, has been linked to fires by arcing. This deficient practice affected staff and visitors of the data room on the date of the survey. The facility is licensed for 41 SNF/NF beds and had a census of 31 on the day of the survey.

Findings include:

During the facility tour conducted on April 4, 2017 from approximately 10:00 AM to 12:30 PM, observation of the data room in the 100 hall revealed a portable air compressor plugged into a relocatable power tap. Asked why the RPT was being used for the compressor, the Administrator stated there was not another outlet close enough to supply power.

Actual NFPA standard:

NFPA 70

Chapter 4: Equipment for General Use

ARTICLE 400: Flexible Cords and Cables

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

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1033 WEST QUINN ROAD

POCATELLO, ID 83202

**DATE SURVEY COMPLETED**

04/04/2017
### Statement of Deficiencies and Plan of Correction

| (X1) Provider/Supplier/Clinic Identification Number: | 135136 |
| (X2) Multiple Construction: | A. Building 01 - Quinn Meadows |
| B. Wing | |

#### Name of Provider or Supplier

**Quinn Meadows Rehabilitation & Care Center**

#### Street Address, City, State, Zip Code

1033 West Quinn Road
POCATELLO, ID 83202

<table>
<thead>
<tr>
<th>(X4) 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>(X5) Completion Date</th>
</tr>
</thead>
</table>
| K 511             | Continued From page 17
ceilings, suspended ceilings, dropped ceilings, or floors
(3) Where run through doorways, windows, or similar openings
(4) Where attached to building surfaces
Exception to (4): Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of 368.56(B)
(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
(7) Where subject to physical damage | K 511 cont...
The Administrator or designee will do a visual observation of the portable air compressor to ensure it is plugged into a direct electrical outlet and not a relocatable power tap.
Monitoring will start on 5/4/2017.
This will be done weekly x 4, the every 2 weeks x 4, then monthly x 3.
The administrator or designee will present to the quarterly QA&A committee the findings and/or corrective actions taken.
Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A committee quarterly meeting. | 5/2/17 |
| K 918 SS=F        | Electrical Systems - Essential Electric System
Maintenance and Testing
The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.
Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in | K-918
Corrective action(s) accomplished for those residents found to have been affected by the deficient practice:
A column for the load acquired during the monthly generator load testing has been added to the monthly generator load testing log.
Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following: | 5/2/2017 |
K 918

**Summary Statement of Deficiencies**

**Prefix (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)**

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
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<td>K 918 cont...</td>
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- All residents may have the potential to be affected by this deficiency; hence by 5/01/2017 the Administrator or designee will perform a monthly load test of the generator and document the load acquired.

- The facility only has the one generator.

- Measures that will be put into place or systemic changes that will be made to ensure that the deficient practice does not recur includes the following:

  - A 1:1 in-service will be provided to the Maintenance Director of the importance of ensuring that the load acquired during the monthly generator load testing is documented on the monthly generator load testing log.

  - How the corrective action(s) will be monitored to ensure the deficient practice will not recur:

    - Monitoring will be done through:
      - The Administrator or designee will do a visual observation of the monthly generator load testing log to ensure that the load acquired is documented.


    - This will be done weekly x 4, the every 2 weeks x 4, then monthly x 3.

    - The administrator or designee will present to the quarterly QA&A committee the findings and/or corrective actions taken.
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
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| K918 | K918 | cont... | Continued From page 19 
the Maintenance Supervisor stated he had documented the load based on instructions he received from his predecessor. 

Actual NFPA Standard: 

8.4 Operational Inspection and Testing, 
8.4.1a EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly. 

8.4.2.4 Spark-ignited generator sets shall be exercised at least once a month with the available EPSS load for 30 minutes or until the water temperature and the oil pressure have stabilized. 

K927 | SS=D | Corrective action(s) accomplished for those residents found to have been affected by the deficient practice: 

The mechanical ventilation fan in the oxygen trans-fill space on the west side of the facility has been replaced. 

Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following: 

This deficiency is an isolated deficiency as reflected in the Statement of deficiencies - form CMS-2567. 

There is only the one oxygen trans-filling area in the facility and only one mechanical ventilation fan in the trans-filling area. 

K918 cont... 

Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A committee quarterly meeting. 

The mechanical ventilation fan in the oxygen trans-fill space on the west side of the facility has been replaced. 

Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken includes the following: 

This deficiency is an isolated deficiency as reflected in the Statement of deficiencies - form CMS-2567. 

There is only the one oxygen trans-filling area in the facility and only one mechanical ventilation fan in the trans-filling area. 

<table>
<thead>
<tr>
<th>(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - QUINN MEADOWS</th>
<th>(X3) DATE SURVEY COMPLETED</th>
<th>04/04/2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME OF PROVIDER OR SUPPLIER</td>
<td>QUINN MEADOWS REHABILITATION &amp; CARE CENTER</td>
<td>STREET ADDRESS, CITY, STATE, ZIP CODE</td>
</tr>
<tr>
<td>PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:</td>
<td>135136</td>
<td></td>
</tr>
<tr>
<td>ID PROVIDER'S PLAN OF CORRECTION</td>
<td>PREFIX</td>
<td>TAG</td>
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## Statement of Deficiencies and Plan of Correction

### Provider/Supplier/Clinic Identification Number:
135136

### Name of Provider or Supplier
Quinn Meadows Rehabilitation & Care Center

### Street Address, City, State, Zip Code
1033 West Quinn Road
POCATELLO, ID 83202

### Summary Statement of Deficiencies

**ID** | **Prefix** | **Tag** | **Description** |
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K 927 | | | Continued deficient practice affected staff and visitors utilizing the oxygen transfill space on the west side of the facility. The facility is licensed for 41 SNF/NF beds and had a census of 31 on the day of the survey.

Findings include:

During the facility tour conducted on April 4, 2017 from approximately 12:30 PM to 2:30 PM, observation and operational testing of the fan in the oxygen transfill space on the west side of the facility revealed the fan was not operational.

Actual NFPA standard:

11.5.2.3 Transfilling Liquid Oxygen. Transfilling of liquid oxygen shall comply with 11.5.2.3.1 or 11.5.2.3.2, as applicable.

11.5.2.3.1 Transfilling to liquid oxygen base reservoir containers or to liquid oxygen portable containers over 344.74 kPa (50 psi) shall include the following:

1. A designated area separated from any portion of a facility wherein patients are housed, examined, or treated by a fire barrier of 1 hour fire-resistive construction.
2. The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring.
3. The area is posted with signs indicating that transfilling is occurring and that smoking in the immediate area is not permitted.
4. The individual transfilling the container(s) has been properly trained in the transfilling procedures.

### Provider’s Plan of Correction

**ID** | **Prefix** | **Tag** | **Description** |
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K 927 | | | Measures that will be put into place or systemic changes that will be made to ensure that the deficient practice does not recur includes the following:

To ensure that the deficient practice does not recur, starting on 4/28/2017 the Administrator or designee will do a daily check to ensure that the mechanical ventilation fan in the oxygen trans-filling room is operational and working.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur:

Monitoring will be done through:

1) do a visual observation of the mechanical ventilation fan in the oxygen transfilling area to ensure it is operational and working;
2) do a visual observation of the daily log to ensure the mechanical ventilation fan in the oxygen transfilling area is being checked and completed daily.

Monitoring will start on 5/4/2017.

This will be done weekly x 4, the every 2 weeks x 4, then monthly x 3.

The administrator or designee will present to the quarterly QA&A committee the findings and/or corrective actions taken.

Compliance, continuation/discontinuation of monitoring will be discussed during the QA&A committee quarterly meeting.