February 27, 2019

Casey Kemmerer, Administrator
Teton Post Acute Care & Rehabilitation
3111 Channing Way
Idaho Falls, ID 83404-7534

Provider #: 135138

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Kemmerer:

On February 21, 2019, a Facility Fire Safety and Construction survey was conducted at Teton Post Acute Care & Rehabilitation by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide ONLY ONE completion date for each federal and state tag in column (X5) Completion Date to signify when
you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to 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 **March 12, 2019.** Failure to submit an acceptable PoC by **March 12, 2019,** may result in the imposition of civil monetary penalties by **April 3, 2019.**

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 may be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **March 28, 2019,** (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 22, 2019.** A change in the seriousness of the deficiencies on **April 7, 2019,** may result in a change in the remedy.
The remedy, which will be recommended if substantial compliance has not been achieved by March 28, 2019, includes the following:

Denial of payment for new admissions effective May 21, 2019.
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 August 21, 2019, 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 February 21, 2019, 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 **March 12, 2019**. If your request for informal dispute resolution is received after **March 12, 2019**, 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

Enclosures
The Facility is a single-story Type V (III) construction, built in 1988. The building is approximately 43,000 square feet, and is composed of a service wing, a center core, and four resident wings. The building is fully sprinklered with a dry system covering the attic and a wet system with quick response heads covering the resident care areas. The building has a manual fire alarm system with corridor smoke detection interconnected with the sprinkler flow switches. The Essential Electrical System is supplied by a natural gas powered, on-site automatic generator. There are multiple exits to grade equipped with delayed egress devices. The facility is currently licensed for 88 SNF/NF beds with a census of 66 on the dates of the survey.

The following deficiencies were cited during the annual fire/life safety survey conducted on February 20 - 21, 2019. 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:

Linda Chaney
Health Facility Surveyor
Facility Fire Safety and Construction

Corrective Action: The single-leaf, self-closing smoke door to the dining area from the corridor was fixed so that there was no magnetic hold device that keep the door open. The door will be kept closed with a self-closer to make sure it latches when not in use. All residents, staff, and visitors in the dining room would be affected.

The two single-single leaf, self-closing doors between the kitchen and the corridors were adjusted with a self-closer that was added to the door to make sure it latches when closed. All residents, staff and visitors would be affected. The self-closer was replaced that was on the smoke barrier door at the entrance to the 400 hallway to ensure when released the door would latch. All residents staff and visitors down the 400 hall would be affected.

Identification of others: All self-closing devices will be audited by the maintenance director to validate that the self-closing mechanism keeps the door closed and latched. The audit will be conducted no later than 3/15/2019.

Systematic Changes: An in-service will be conducted by the NHA on or before 3/15/2019. The in-service will educate the maintenance director on the use of self-closing devices and to make sure they are closed at all times or held open by a release device that will close with the fire alarm.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**
TETON POST ACUTE CARE & REHABILITATION

**STREET ADDRESS, CITY, STATE, ZIP CODE**
3111 CHANNING WAY
IDAHO FALLS, ID 83404

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
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<th>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>K223</td>
<td>continued From page 1</td>
<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: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure self-closing doors in smoke barriers were free from obstruction. 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 residents utilizing the dining room, staff and visitors on the dates of the survey. Findings include: During the facility tour on February 21, 2019, from approximately 1:00 PM to 4:00 PM, observation and operational testing of doors in the facility revealed the following: 1.) The single-leaf, self-closing smoke door to the dining area from the corridor was held open by means other than a magnetic hold open device. 2.) Two (2) single-leaf, self-closing doors between the kitchen and the corridor would not self-close and latch when opened and released. 3.) Smoke barrier doors at the entrance to the 400 hallway did not close and latch when released from the magnetic hold open devices, leaving an approximately 9-inch gap between the</td>
<td>Monitor: An audit tool will be developed by the maintenance director or designee no later than 3/15/2019. The tool will be utilized to monitor all self-closing mechanism to validate that the door closes and latches. The audit will be done monthly for 3 months and the results of the audit will be brought to the monthly Quality Assurance meeting for review and recommendations for 3 months and as needed.</td>
<td>March 15, 2019</td>
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K 223 Continued From page 2 doors.

When asked, the Maintenance Director stated the facility believed it was okay to hold open the door to the dining room and did not realize it was protecting the dining/kitchen smoke compartment from the corridor. He further stated the facility was unaware the doors to the kitchen and 400 hallway would not self-close and latch.

Actual NFPA standard:

NFPA 101
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.

7.2.1.8.2 In any building of low or ordinary hazard contents, as defined in 6.2.2.2 and 6.2.2.3, or where approved by the authority having jurisdiction, door leaves shall be permitted to be automatic-closing, provided that all of the following criteria are met:
(1) Upon release of the hold-open mechanism, the leaf becomes self-closing.
(2) The release device is designed so that the leaf instantly releases manually and, upon release, becomes self-closing, or the leaf can be readily closed.
(3) The automatic releasing mechanism or medium is activated by the operation of approved smoke detectors installed in accordance with the
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<th>(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:</th>
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**NAME OF PROVIDER OR SUPPLIER**

TETON POST ACUTE CARE & REHABILITATION

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

3111 CHANNING WAY
IDAHO FALLS, ID 83404

**DATE SURVEY COMPLETED**

02/21/2019

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**K 223 Continued From page 3**

requirements for smoke detectors for door leaf release service in NFPA 72, National Fire Alarm and Signaling Code.

(4) Upon loss of power to the hold-open device, the hold-open mechanism is released, and the door leaf becomes self-closing.

**K 353 Sprinkler System - Maintenance and Testing**

CFR(s): 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
- 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 REQUIREMENT 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, corrosion or foreign material. Failure to maintain fire sprinkler pendants free of obstructions could hinder water distribution patterns, restrain thermal elements, and render a sprinkler inoperable or ineffective during a fire.

**K Tag 353 Corrective Action:**

The fire sprinkler pendant in the storage room in the 400 hallways was replaced on 3/3/2019. The fire sprinkler pendant in the physical therapy office was replaced on 3/3/2019. The fire sprinkler pendant in the dining area was cleaned to make sure there was no grease, dust and lint on the pendant on 3/3/2019.

**Identifications of others:** All fire sprinkler pendants will be check to validate that the pendants are free of corrosion, foreign materials, paint, and physical damaged. The audit will be conducted no later than 3/15/2019.

**Systematic Changes:** An in-service will be conducted by the NHA no later than 3/15/2019. The in-service will educate the maintenance director on fire sprinkler pendants. The fire sprinkler pendants need to be free of corrosion, foreign materials, paint, and physical damage.

**Monitor:** An audit tool will be developed by the maintenance director or designee no later than 3/15/2019. The tool will be utilized to monitor fire sprinkler pendants to validate that the pendants are free of corrosion, foreign materials, paint, and physical damaged. The audit will be done monthly for 3 months and the results of the audit will be brought to the monthly Quality Assurance meeting for review and recommendation for 3 months and as needed.

**Completion:**
March 15, 2019

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**K 353**

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**Completion:**
March 15, 2019
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
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<th>(X3) DATE SURVEY COMPLETED</th>
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<tr>
<td>135138</td>
<td>A. BUILDING 01 - TETON POST ACUTE CARE &amp; REHABILITATION</td>
<td>02/21/2019</td>
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**NAME OF PROVIDER OR SUPPLIER**  
TETON POST ACUTE CARE & REHABILITATION

**STREET ADDRESS, CITY, STATE, ZIP CODE**  
3111 CHANNING WAY  
IDAHO FALLS, ID 83404

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<td>K 353</td>
<td>Continued From page 4</td>
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Event. This deficient practice affected 66 residents, staff and visitors on the dates of the survey.

Findings include:

Observation of fire sprinkler pendants during the facility tour on February 21, 2019, from approximately 1:00 PM to 4:00 PM, revealed the following sprinkler pendants were obstructed by non-factory paint or foreign material:

1. Storage room in the 400 hallway had a painted sprinkler pendant.  
2. Physical therapy office had a sprinkler pendant with paint or foreign material on it. Substance was unknown but was hot pink and attached to the sprinkler.  
3. Sprinkler pendant above the grilling area in the dining room was loaded with what appeared to be grease, dust and lint.

When asked, the Maintenance Director stated the facility was not aware the sprinklers pendants were obstructed.

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
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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

135138

#### (X2) MULTIPLE CONSTRUCTION

A. BUILDING 01 - TETON POST ACUTE CARE & REHABILITATION

B. WING __________________

#### (X3) DATE SURVEY COMPLETED

02/21/2019

### NAME OF PROVIDER OR SUPPLIER

TETON POST ACUTE CARE & REHABILITATION

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

3111 CHANNING WAY

IDAHO FALLS, ID 83404

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<tr>
<td>K 353</td>
<td>Continued From page 5 (3) Physical damage (4) Loss of fluid in the glass bulb heat responsive element (5) *Loading (6) Painting unless painted by the sprinkler manufacturer</td>
<td>K 353</td>
<td>Corrective Action: The maintenance supervisor will adjust and/ or repair the door to room #103, #107, and #204 to ensure that the door will stay latched when closed and when five pounds of pressure is applied</td>
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<td>K 363</td>
<td>Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or 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</td>
<td>K 363</td>
<td>Identification of others: As there may be other doors to resident rooms that do not latch properly, the maintenance supervisor or designee will conduct a 100% inspection of the resident room doors no later than 3/15/2019. Any doors that are identified as not latching properly or not staying latched when 5 pounds of pressure is applied will be adjusted and/or repaired at that time.</td>
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<td>Systematic Changes: An in-service will be conducted by the NHA no later than 3/15/2019. The in-service will educate maintenance director on the need for resident rooms to latch properly and staying latched when 5 pounds of pressure is applied.</td>
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<td>Monitor: An audit tool will be developed by the maintenance director no later than 3/15/2019. The audit toll will be used to validate that all resident room doors properly latch and stay latched when 5 pounds of pressure is applied. The audit will be conducted monthly times 3 months. The results will be brought to the monthly Quality Assurance meeting for review and recommendations for 3 months and as needed.</td>
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<td>Completion: March 15, 2019</td>
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*Event ID: 67DS21  Facility ID: MDS001775  If continuation sheet Page 6 of 10*
K 363 Continued From page 6
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 485
Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.
This REQUIREMENT 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, preventing defend in place. This deficient practice has the potential to affect 5 residents, staff, and visitors on the dates of survey.

Findings include:
During the facility tour on February 21, 2019, from approximately 1:00 PM to 4:00 PM, observation and operational testing of resident room doors revealed resident rooms #103, #107 and #204 would not latch when fully closed. When asked, the Maintenance Director stated the facility was unaware the doors would not latch.

Actual NFPA Standards:
19.3.6.3* Corridor Doors.
19.3.6.3.5* Doors shall be provided with a means for keeping the door closed that is acceptable to the authority having Jurisdiction, and the following requirements also shall apply:
(1) The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is
K 363 Continued From page 7
applied at the latch edge of the door.
(2) Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.7.

K 927 Gas Equipment - Transfilling Cylinders
CFR(s): NFPA 101

Gas Equipment - Transfilling Cylinders
Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99)

This REQUIREMENT is not met as evidenced by:
Based on observation and operational testing, the facility failed to ensure liquid oxygen transfilling was conducted in accordance with NFPA 99. Failure to transfill liquid oxygen in a separate area of the facility, protected by a 1-hour fire barrier, could result in an oxygen rich environment, increasing the potential for combustion. This deficient practice affected approximately four (4) residents in the common at the nurse's station, staff and visitors on the dates of the survey.

Findings include:
During the facility tour on February 21, 2019, from
### Statement of Deficiencies and Plan of Correction

#### (X1) Provider/Supplier/Clinic Identification Number:
135138

**Name of Provider or Supplier:**

Teton Post Acute Care & Rehabilitation

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

3111 Channing Way

Idaho Falls, ID 83404

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<tr>
<th>ID</th>
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<th>Provider's Plan of Correction</th>
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| K 927 | Continued From page 8 | approximately 1:00 PM to 4:00 PM, observation of the liquid oxygen transfilling area, revealed the closet being used for transfilling was approximately 8' in length, 30'' in depth with two (2) 1-hour, self-closing doors protecting the area from the corridor. The closet had approximately seven (7), LOX transfilling cylinders, which filled the closet, preventing a person from entering the closet to transfill oxygen. The following observations were made:

1.) A staff member transfilling oxygen was observed blocking the self-closing door open with their body, to have sufficient room to transfill, thus eliminating the 1-hour separation from the corridor during transfilling operations.
2.) Review of staff oxygen training documents revealed staff were not trained to enter the closet and secure the door behind them before transfilling.
3.) No signage was present indicating transfilling was occurring in this space.

When asked, the Maintenance Director stated the facility was unaware the doors were not allowed to be open to the corridor when transfilling was in process, or the need to train staff on this requirement. They were also unaware of the required signage.

**Actual NFPA standard:**

NFPA 99

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

11.5.2.3.1 Transferring to liquid oxygen base reservoir containers or to liquid oxygen portable

**Monitor:** An audit tool will be developed by the maintenance director or designee no later than 3/15/2019. The tool will be utilized to monitor staff transfilling liquid oxygen. The audit will validate that proper signage is on the door for transfilling, and to validate that staff is transfilling with the door being closed. This audit will be done weekly for 4 weeks than monthly for 2 months. The results will be brought to the monthly Quality Assurance meeting for review and recommendations for 3 months and as needed.

**Completion:**

March 15, 2019
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.
February 27, 2019

Casey Kemmerer, Administrator
Teton Post Acute Care & Rehabilitation
3111 Channing Way
Idaho Falls, ID 83404-7534

Provider #: 135138

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Mr. Kemmerer:

On February 21, 2019, an Emergency Preparedness survey was conducted at Teton Post Acute Care & Rehabilitation by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. Your facility was found to be in substantial compliance with Federal regulations during this survey.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, which states that the facility complies with the requirements of CFR 42, 483.70(a) of the federal requirements. This form is for your records only and does not need to be returned.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact this office at (208) 334-6626, option 3.

Sincerely,

Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/Ij
Enclosures
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER
TETON POST ACUTE CARE & REHABILITATION

STREET ADDRESS, CITY, STATE, ZIP CODE
3111 CHANNING WAY
IDAHO FALLS, ID 83404

ID PREFIX TAG

A. BUILDING

B. WING

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

E 000 Initial Comments

The Facility is a single-story Type V (III) construction, built in 1988. The building is approximately 43,000 square feet, and is composed of a service wing, a center core, and four resident wings. The building is fully sprinklered with a dry system covering the attic and a wet system with quick response heads covering the resident care areas. The building has a manual fire alarm system with corridor smoke detection interconnected with the sprinkler flow switches. The Essential Electrical System is supplied by a natural gas powered, on-site automatic generator. There are multiple exits to grade equipped with delayed egress devices. The facility is currently licensed for 88 SNF/NF beds with a census of 66 on the dates of the survey.

The facility was found to be in substantial compliance during the annual Emergency Preparedness Survey conducted on February 20-21, 2019. The facility was surveyed under the Emergency Preparedness Rule established by CMS, in accordance with 42 CFR 483.73.

The Survey was conducted by:

Linda Chaney
Health Facility Surveyor
Facility Fire Safety and Construction

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.