August 21, 2019

R. Ryan Beckman, Administrator
Grangeville Health & Rehabilitation Center
410 East North Second Street
Grangeville, ID 83530-2258

Provider #: 135080

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Beckman:

On August 13, 2019, a Facility Fire Safety and Construction survey was conducted at Grangeville Health & Rehabilitation 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 **September 3, 2019.** Failure to submit an acceptable PoC by **September 3, 2019,** may result in the imposition of civil monetary penalties by **September 25, 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 **September 17, 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 **November 11, 2019.** A change in the seriousness of the deficiencies on **September 27, 2019,** may result in a change in the remedy.
The remedy, which will be recommended if substantial compliance has not been achieved by September 17, 2019, includes the following:

Denial of payment for new admissions effective November 13, 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 February 13, 2020, 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 August 13, 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 **September 3, 2019**. If your request for informal dispute resolution is received after **September 3, 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
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:
136080

(X2) MULTIPLE CONSTRUCTION
A. BUILDING 01 - ENTIRE BUILDING

B. WING

(X3) DATE SURVEY COMPLETED
08/13/2019

NAME OF PROVIDER OR SUPPLIER
GRANGEVILLE HEALTH & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
410 EAST NORTH SECOND STREET
GRANGEVILLE, ID 83530

(X4) ID PREFIX TAG

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

ID PREFIX TAG

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

K 000 INITIAL COMMENTS

The facility is a single story, type V (111) structure originally constructed in 1967. It is fully sprinklered and equipped with an interconnected fire alarm system, including smoke detection in corridors and open spaces. The building has a partial basement housing the boiler, fire suppression system riser and transfer switch to the emergency generator. The facility is currently licensed for 60 SNF/NF beds and had a census of 42 on the dates of the survey.

The following deficiencies were cited during the annual Fire/Life Safety survey conducted on August 12 - 13, 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 & Construction

Means of Egress - General
SS=F CFR(s): NFPA 101

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, 19.2.1, 7.1.10.1
This REQUIREMENT is not met as evidenced by:
Based on observation, operational testing and

K 000

"This plan of correction is submitted as required under Federal and State regulations and statutes applicable to skilled nursing facilities. This plan of correction does not constitute an admission of liability, and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyor's conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied."

Please accept this plan of correction as our credible allegation of compliance.

RECEIVED
SEP 03 2019
FACILITY STANDARDS

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

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.
K 211 Continued From page 1

The facility failed to ensure means of egress were maintained free of all obstructions to full instant use. Failure to maintain means of egress for full, instant use, could hinder the safe evacuation of residents during an emergency. This deficient practice affected 42 residents and staff on the dates of the survey.

Findings include:

During the facility tour on August 13, 2019, from approximately 9:00 AM to 11:00 AM, observation and operational testing of exit doors revealed the following:

1.) Exit doors at the end of the 100 and 300 hallways required more than 15 lbf. to open to the minimum width.
2.) The main entrance/exit doors to the facility had a deadbolt lock, making them non-single operational.

When asked, at approximately 9:15 AM during the facility tour, the Maintenance Director stated the facility was not aware the main doors entering the facility could not have a deadbolt lock on them and were required to be single-operational. He further stated, the exit doors at the end of the 100 and 300 hallways are not used often and the facility was aware, that due to varying conditions outside, the doors, on occasion, would drag or catch on the concrete, making them very difficult to open/close.

Actual NFPA standard:

NFPA 101
19.2 Means of Egress Requirements.
19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access

K 211
Resident Specific:
Please see systemic changes.

Other Residents:
Please see systemic Changes

Systemic Changes:

1) Exit doors at the end of the 100 hall and 300 hall have been inspected by "Window's Doors, and More". Parts are on order to replace hinging and thresholds in order to reduce required activation pressure.

2) Main entrance doors inspected by "Window's Doors and More". Deadbolt will be removed and replaced with a plug.

Monitors:

Monthly inspection form added to routine maintenance manual to track and ensure inspections occur. Inspection will ensure doors are free of all obstructions and or impediments. Inspection will also check to ensure required pressure to activate door latch does not exceed 15# and required pressure to move door leaf does not exceed 30#.

Date of Compliance:
September 17th 2019
<table>
<thead>
<tr>
<th>(X4) ID PREFIX</th>
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<th>ID PREFIX</th>
<th>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>
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</thead>
<tbody>
<tr>
<td>K 211</td>
<td></td>
<td>Continued From page 2 shall be in accordance with Chapter 7, unless otherwise modified by 19.2.2 through 19.2.11.</td>
<td>K 211</td>
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<tr>
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<td>1.) 7.1.10 Means of Egress Reliability. 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.</td>
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<td>2.) 7.2.1.4.5 Door Leaf Operating Forces. 7.2.1.4.5.1 The forces required to fully open any door leaf manually in a means of egress shall not exceed 15 lbf (67 N) to release the latch, 30 lbf (133 N) to set the leaf in motion, and 15 lbf (67 N) to open the leaf to the minimum required width, unless otherwise specified as follows: (1) The opening forces for interior side-hinged or pivoted-swinging door leaves without closers shall not exceed 5 lbf (22 N). (2) The opening forces for existing door leaves in existing buildings shall not exceed 50 lbf (222 N) applied to the latch stile. (3) The opening forces for horizontal-sliding door leaves in detention and correctional occupancies shall be as provided in Chapters 22 and 23. (4) The opening forces for power-operated door leaves shall be as provided in 7.2.1.9.</td>
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<tr>
<td>K 291</td>
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<td>Emergency Lighting</td>
<td>K 291</td>
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<td>SS=F</td>
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<td>Emergency Lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure</td>
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doors equipped with special locking arrangements, were provided with battery powered emergency lighting. Failure to provide emergency lighting for doors equipped with delayed egress potentially hinders identification of exits utilized for resident egress during low light conditions. This deficient practice affected 42 residents and staff on the dates of the survey.

Findings include:

During the facility tour conducted on August 13, 2019, from approximately 9:00 AM - 11:00 AM, observation of the exit doors at the end of all three resident sleeping corridors, revealed all were equipped with magnetic locking arrangements, which included a delayed egress component, but none had the required emergency lighting.

Actual NFPA standard:

19.2.9 Emergency Lighting.
19.2.9.1 Emergency lighting shall be provided in accordance with Section 7.9.

7.9 Emergency Lighting.
7.9.1 General.
7.9.1.1* Emergency lighting facilities for means of egress shall be provided in accordance with Section 7.9 for the following:
(1) Buildings or structures where required in Chapters 11 through 43
(2) Underground and limited access structures as addressed in Section 11.7
(3) High-rise buildings as required by other sections of this Code
(4) Doors equipped with delayed-egress locks
(5) Stair shafts and vestibules of smokeproof
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>135080</td>
<td>A. BUILDING 01 - ENTIRE BUILDING</td>
</tr>
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</table>

**NAME OF PROVIDER OR SUPPLIER**

GRANGEVILLE HEALTH & REHABILITATION CENTER

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

410 EAST NORTH SECOND STREET
GRANGEVILLE, ID 83530

**K 291** Continued From page 4

enclosures, for which the following also apply:
(a) The stair shaft and vestibule shall be permitted to include a standby generator that is installed for the smokeproof enclosure mechanical ventilation equipment.
(b) The standby generator shall be permitted to be used for the stair shaft and vestibule emergency lighting power supply.

**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.

1) Facility will conduct monthly visual inspection of wet sprinkler system gauges and control valves.
2) Facility will conduct monthly visual inspection of sprinkler heads in high moisture areas (Kitchen, Laundry, and Refrigeration units)

Monitors:

1) Monthly inspection form added to routine maintenance manual to track and ensure inspections occur. Inspection will verify condition and working order of gauges and valves.
2) Monthly inspection form added to routine maintenance manual to visually inspect sprinkler heads in high moisture areas. Any sprinklers noted to be out of compliance will be identified and replaced. This will be an internal inspection to supplement the already established yearly inspection conducted by **[redacted]**

Date of Compliance

September 17th 2019
K 353 Continued From page 5

render the facility not fully sprinklered after an
activation or repair. This deficient practice
affected 42 residents and staff on the dates of the
survey.

Findings include:

1.) During review of provided facility inspection
and testing records on August 12, 2019, from
approximately 11:00 AM - 4:30 PM, no
documentation could be produced for a monthly
visual inspection of wet sprinkler system gauges
and control valves. When asked on August 12,
2019, at approximately 3:00 PM, the Maintenance
Director stated the facility was performing weekly,
if not daily, checks of the sprinkler system gauges
and control valves, but was unaware visual
inspections of the sprinkler system were required
to be documented.

2.) During the facility tour on August 13, 2019,
from approximately 10:20 AM to 10:40 AM,
observation of the kitchen revealed a total of two
(2) corroded sprinkler heads. When discovered,
interview of the Maintenance Director revealed
the facility was unaware of the corroded sprinkler heads.

Actual NFPA standard:

NFPA 25

1.) 5.24 Gauges.
2.4.1 Gauges on wet pipe sprinkler systems
shall be inspected monthly to ensure that they are
in good condition and that normal water supply
pressure is being maintained.
Chapter 13 Valves, Valve Components, and Trim
13.3.2 Inspection
## Statement of Deficiencies and Plan of Correction

### Provider/Supplier/CLIA Identification Number:

<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>
</tr>
</thead>
</table>
| K 353         | Continued From page 6  
13.3.2.1 Valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly.  
13.3.2.2 The valve inspection shall verify that the valves are in the following condition: (1) In the normal open or closed position (2) Sealed, locked, or supervised (3) accessible (4) Provided with correct wrenches (5) free from external leaks (6) Provided with applicable identification  
14.4.1.1 Alarm valves and system riser check valves shall be externally inspected monthly and shall verify the following: (1) The gauges indicate normal supply water pressure is being maintained (2) The valve is free of physical damage (3) All valves are in the appropriate open or closed position (4) The retarding chamber or alarm drains are not leaking.  
2.) 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 (3) Physical damage (4) Loss of fluid in the glass bulb heat responsive element (5) *Loading (6) Painting unless painted by the sprinkler manufacturer | K 353 |

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

**Grangeville, ID 83530**

### Date Survey Completed:

08/13/2019

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*Note: The table continues on the next page.*
### Summary Statement of Deficiencies

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
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<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>Provider's Plan of Correction</th>
<th>Date of Compliance</th>
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<tbody>
<tr>
<td>K 363</td>
<td>Continued From page 7</td>
<td></td>
<td>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 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.</td>
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<td>September 17th 2019</td>
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</table>
K 363 Continued From page 8

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, preventing defend in place. This deficient practice has the potential to affect 3 residents and staff on the dates of the survey.

Findings include:

During the facility tour on August 13, 2019, from approximately 9:00 AM to 11:00 AM, observation and operational testing of the resident room doors revealed room #106 had a 1" gap, and room #308 had a 3/4" gap between the face of the door and the frame of the door when fully closed.

Room #302 was very difficult to close/open and did not latch without great force. When asked during the facility tour at approximately 10:50 AM, the Maintenance Director stated the facility was unaware of the door gaps but had just repaired door #302 and was unaware it was having problems operating again.

Actual NFPA Standards:

NFPA 101
19.3.6.3* Corridor Doors.
19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be doors constructed to resist the passage of smoke and shall be constructed of materials such as the following:

(1) 1-3/4 in. (44 mm) thick, solid-bonded core wood
(2) Material that resists fire for a minimum of 20
<table>
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<tr>
<th>ID Prefix Tag</th>
<th>Summary Statement of Deficiencies (Each deficiency must be preceded by full regulatory or LSC identifying information)</th>
<th>ID Prefix Tag</th>
<th>Provider's Plan of Correction (Each corrective action should be cross-referenced to the appropriate deficiency)</th>
<th>Completion Date</th>
</tr>
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<tbody>
<tr>
<td>K 363</td>
<td>Continued From page 9 minutes</td>
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**NAME OF PROVIDER OR SUPPLIER**
GRANGEVILLE HEALTH & REHABILITATION CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**
410 EAST NORTH SECOND STREET
GRANGEVILLE, ID 83530

**DATE SURVEY COMPLETED**
08/13/2019

**ID PREFIX TAG**
135080

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**MULTIPLE CONSTRUCTION**

A. BUILDING 01 - ENTIRE BUILDING

**FACILITY ID:** MDS001230
August 21, 2019

R. Ryan Beckman, Administrator
Grangeville Health & Rehabilitation Center
410 East North Second Street
Grangeville, ID 83530-2258

Provider #: 135080

RE: EMERGENCY PREPAREDNESS SURVEY REPORT COVER LETTER

Dear Mr. Beckman:

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- 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.

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  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.
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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 September 3, 2019. If your request for informal dispute resolution is received after September 3, 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
**Statement of Deficiencies and Plan of Correction**

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

135080

**Name of Provider or Supplier:**

Grangeville Health & Rehabilitation Center

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

410 East North Second Street
Grangeville, ID 83530

**Survey Completion Date:**

08/13/2019

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<table>
<thead>
<tr>
<th>Event 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>
</tr>
</thead>
<tbody>
<tr>
<td>E 000</td>
<td>Initial Comments</td>
<td></td>
<td>The facility is a single story, type V (111) structure originally constructed in 1967. It is fully sprinklered and equipped with an interconnected fire alarm system, including smoke detection in corridors and open spaces. The building has a partial basement housing the boiler, fire suppression system riser and transfer switch to the emergency generator. The facility is currently licensed for 60 SNF/NF beds and had a census of 42 on the dates of the survey.</td>
<td>&quot;This plan of correction is submitted as required under Federal and State regulations and statutes applicable to skilled nursing facilities. This plan of correction does not constitute an admission of liability, and such liability is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyor's conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied.&quot; Please accept this plan of correction as our credible allegation of compliance.</td>
<td></td>
</tr>
<tr>
<td>E 039</td>
<td>EP Testing Requirements</td>
<td>CFR(s): 483.73(d)(2)</td>
<td>(2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following:</td>
<td>FACILITY STANDARDS</td>
<td></td>
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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.
E 039 Continued From page 1 following:

(i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.

(ii) Conduct an additional exercise that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or individual, facility-based.

(B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the [facility’s] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility’s] emergency plan, as needed.

*For RNHCl at §403.748 and OPOs at §486.360 (d)(2) Testing. The [RNHCl and OPO] must conduct exercises to test the emergency plan. The [RNHCl and OPO] must do the following:

(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an
**E039**  
Continued From page 2

equipment plan.  
(ii) Analyze the [RNHCl's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCl's and OPO's] emergency plan, as needed.

This REQUIREMENT is not met as evidenced by:

Based on record review and interview, it was determined the facility failed to test the emergency preparedness plan annually. Failure to test the emergency preparedness plan annually, has the potential to hinder staff response during a disaster. This deficient practice affected 42 residents and staff on the dates of the survey.

Findings Include:

Review of the facility Emergency Preparedness (EP) plan on August 12 - 13, 2019, from approximately 12:00 PM to 4:30 PM, revealed a written EP testing program, and a facility-based tabletop exercise. However, there had not been a full-scale, community-based exercise since May 12, 2018. When the Maintenance Director was questioned on August 12, 2019, at approximately 3:00 PM, he stated the facility was planning to participate in a community-based full-scale exercise next month, September 2019.

Reference:

42 CFR 483.73 (d) (2)