



C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

IDAHO DEPARTMENT OF
HEALTH & WELFARE

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
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CERTIFIED MAIL: 70073020000140446666

January 31, 2012

Joseph Reese, Administrator
Idaho Falls Care & Rehabilitation Center
3111 Channing Way
Idaho Falls, Idaho 83404

Provider #: 135107

Dear Mr. Reese:

On **January 24, 2012**, a Facility Fire Safety and Construction survey was conducted at Idaho Falls Care & Rehabilitation Center by the Bureau of Facility Standards/Department of Health & Welfare 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 one that comprises a pattern 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/Plan of Correction, CMS Form 2567L, listing Medicare/Medicaid deficiencies, and a similar form 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/State Tag in column X5 (Complete 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 both the CMS Form 2567L and State Statement of Deficiencies, in the spaces provided, and return the originals to this office.**

Your Plan of Correction (PoC) for the deficiencies must be submitted by **February 13, 2012**. Failure to submit an acceptable PoC by **February 13, 2012**, may result in the imposition of civil monetary penalties by **March 4, 2012**.

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.

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 **February 28, 2012 (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 **February 28, 2012**. A change in the seriousness of the deficiencies on **February 28, 2012**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **February 28, 2012** includes the following:

Denial of payment for new admissions effective **April 24, 2012**. [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 **July 24, 2012**, 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.

Joseph Reese, Administrator
January 31, 2012
Page 3 of 3

If you believe these deficiencies have been corrected, you may contact Mark P. Grimes, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0036, Phone #: (208) 334-6626, 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 **January 24, 2012** 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:

http://www.healthandwelfare.idaho.gov/Rainbow/Documents/medical/2001_10.pdf
http://www.healthandwelfare.idaho.gov/Rainbow/Documents/medical/2001_10_attach1.pdf
http://www.healthandwelfare.idaho.gov/Rainbow/Documents/medical/2001_10_attach2.pdf

This request must be received by **February 13, 2012**. If your request for informal dispute resolution is received after **February 13, 2012**, 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.

Sincerely,



Mark P. Grimes
Supervisor
Facility Fire Safety and Construction

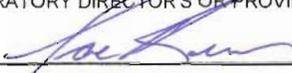
MPG/lj

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135107	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 01/24/2012
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NAME OF PROVIDER OR SUPPLIER IDAHO FALLS CARE & REHABILITATION CEN	STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHANNING WAY IDAHO FALLS, ID 83404
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(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
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K 000	<p>INITIAL COMMENTS</p> <p>The facility is a single story, type V (111) construction with a composite pitched roof and multiple exits to grade with four residential wings, a service wing, and a central core. The facility was originally constructed/completed on November 30, 1988. It is fully sprinklered with fire alarm and detection devices. Currently the facility is licensed for 108 beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on January 24, 2012. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.</p> <p>The Survey was conducted by:</p> <p>Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000	<p>“This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Idaho Falls Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.”</p>	<p style="writing-mode: vertical-rl; transform: rotate(180deg);">FACILITY STANDARDS</p> <p style="writing-mode: vertical-rl; transform: rotate(180deg);">FEB 14 2012</p>
K 029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This Standard is not met as evidenced by:</p>	K 029	<p>K029</p> <ol style="list-style-type: none"> 1. The supply closet door next to room 307 was made to self close and latch on 1/25/12 by the facility Maintenance Director. 2. An audit was completed by the Maintenance Director on 2/9/12 to ensure corridor doors, meet self closer requirements. 3. The Maintenance Director was re-educated by the Administrator on 2/14/12 related to the requirements of self closer doors. 	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Administrator</i>	(X6) DATE <i>2/13/12</i>
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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.

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NAME OF PROVIDER OR SUPPLIER IDAHO FALLS CARE & REHABILITATION CEN			STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHANNING WAY IDAHO FALLS, ID 83404		
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K 029	<p>Continued From page 1</p> <p>Based on observation it was determined that the facility did not ensure that hazardous areas were provided with self closing doors. This deficiency can allow smoke and fire gasses to spread beyond the hazardous area. The facility had a census of sixty three residents on the day of survey. This deficiency affected ten residents and one staff members in one of seven smoke compartments.</p> <p>Findings include:</p> <p>During the tour of the facility on January 24, 2012, at 12:34 PM, observation of the door to the storage room by resident room #307 revealed that the door would not self close when released from the open position. This was observed and noted by the Maintenance Supervisor and Surveyor.</p> <p>Actual NFPA Standard:</p> <p>NFPA 101® Life Safety Code ® 2000 Edition Chapter 19 EXISTING HEALTH CARE OCCUPANCIES 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3</p>	K 029	<p>4. Beginning the week of 2/16/12 the Maintenance Director will audit corridor doors weekly for 1 month and monthly for 2 months to ensure corridor doors meet life safety requirements. The results of these audits will be reported to the Performance Improvement Committee monthly for 3 months. The Performance Improvements Committee will re-evaluate need for further monitoring after 3 months. The Administrator is responsible for monitoring and follow-up.</p> <p>5. Completion Date:</p>	2/16/12	

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K 029	Continued From page 2 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 077 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Piped in medical gas systems comply with NFPA 99, Chapter 4. This Standard is not met as evidenced by: Based on observation and interview it was determined that the facility did not ensure that compressed gas cylinders were properly secured in accordance with NFPA 99. Cylinders that are not properly secured could fall over and possibly rupture. The facility had a census of sixty three residents on the day of survey. This deficiency affected six residents, two staff member in one of seven smoke compartments. Findings include: During the tour of the facility on January 24, 2012 at 12:20 PM, observation of the medical gas	K 077	K077 1. The oxygen cylinders identified were individually secured by the Maintenance Director on 1/25/12. 2. The Maintenance Director completed an audit on 2/9/12 to ensure K sized oxygen cylinders are secured individually. 3. The Maintenance Director was re-educated by the Administrator on 2/14/12 related to the requirements of securing K size oxygen cylinders. 4. Starting the week of 2/16/12 the Maintenance Director will complete audits weekly for 1 month and monthly for 2	

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K 077	<p>Continued From page 3</p> <p>storage manifold room revealed five K sized oxygen cylinders that were not individually secured. When questioned about the cylinders the Maintenance Supervisor stated that he was unaware that the cylinders were required to be individually secured.</p> <p>Actual NFPA Standard:</p> <p>NFPA 99 Standard for Health Care Facilities 1999 Edition 4-3 Level 1 Piped Systems. 4-3.1 Piped Gas Systems (Source and Distribution) - Level 1. 4-3.1.1* Source - Level 1. 4-3.1.1.1 Cylinder and Container Management. Cylinders in service and in storage shall be individually secured and located to prevent falling or being knocked over. (a) * Cylinders or supply containers shall be constructed, tested, and maintained in accordance with the U.S. Department of Transportation specifications and regulations. (b) Cylinder contents shall be identified by attached labels or stencils naming the components and giving their proportions. Labels and stencils shall be lettered in accordance with CGA Pamphlet C-4, Standard Method of Marking Portable Compressed Gas Containers to Identify the Material Contained. (c) Contents of cylinders and containers shall be identified by reading the labels prior to use. Labels shall not be defaced, altered, or removed.</p>	K 077	<p>months to ensure K size oxygen cylinder remain individually secured. The results of these audits will be reported to the Performance Improvement Committee monthly for 3 months. The Performance Improvement Committee will re-evaluate the need for further monitoring after 3 months. The Administrator is responsible for monitoring and follow up.</p> <p>5. Completion Date:</p>	2/16/12
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Bureau of Facility Standards

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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.</p> <p>The facility is a single story, type V (111) construction with a composite pitched roof and multiple exits to grade with four residential wings, a service wing, and a central core. The facility was originally constructed/completed on November 30, 1988. It is fully sprinklered with fire alarm and detection devices. Currently the facility is licensed for 108 beds.</p> <p>The following deficiencies were cited during the annual Fire Life Safety survey conducted on January 24, 2012. The facility was surveyed under IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities.</p> <p>The surveyor conducting the survey was:</p> <p>Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction</p>	C 000		
C 226	<p>02.106 FIRE AND LIFE SAFETY</p> <p>106. FIRE AND LIFE SAFETY. Buildings on the premises used as facilities shall meet all the requirements of local, state and national codes concerning fire and life safety standards that are applicable to health care facilities.</p> <p>This Rule is not met as evidenced by: Refer to the following Federal "K" tags on the</p>	C 226		<p>C226 Please refer to K029 and K077</p>

Idaho form

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

TITLE

(X6) DATE

Bureau of Facility Standards

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C 226	Continued From Page 1 CMS - 2567: 1. K029 Hazardous area doors. 2. K077 Medical gas cylinder storage.	C 226		