



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
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dlhw.idaho.gov

CERTIFIED MAIL: 70090820000028072122

March 9, 2011

Mark Gunnell, Administrator
Idaho Falls Care & Rehabilitation Center
3111 Channing Way
Idaho Falls, Idaho 83404

Provider #: 135107

Dear Mr. Gunnell:

On **March 1, 2011**, 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 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/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 **March 22, 2011**. Failure to submit an acceptable PoC by **March 22, 2011**, may result in the imposition of civil monetary penalties by **April 11, 2011**.

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 **April 5, 2011 (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 **April 5, 2011**. A change in the seriousness of the deficiencies on **April 5, 2011**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **April 5, 2011** includes the following:

Denial of payment for new admissions effective **June 1, 2011**. [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 **September 1, 2011**, 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.

Mark Gunnell, Administrator
March 9, 2011
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 **March 1, 2011** 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 **March 22, 2011**. If your request for informal dispute resolution is received after **March 22, 2011**, 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

RECEIVED

MAR/18/2011/FRI 04:17 PM

MAR 22 2011

P. 001

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FACILITY STANDARDS

Printed: 03/07/2011
FORM APPROVED
OMB NO. 0938-0391

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 03/01/2011
NAME OF PROVIDER OR SUPPLIER IDAHO FALLS CARE & REHABILITATION CEN		STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHANNING WAY IDAHO FALLS, ID 83404	

(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) 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. The following deficiencies were cited during the annual fire/life safety survey conducted on March 1, 2011. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70. The Survey was conducted by: Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction	K 000	"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 deficiencies listed on CMS Form 2567 exist, nor does the facility admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies. The facility reserves the right to challenge in legal and/or regulatory or administrative proceedings all deficiencies, statements, facts, and conclusions that form the basis for each deficiency."	
K 051 SS=F	NFPA 101.LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm	K 051	K 051 NFPA 101 Life Safety Code Standard: Fire Alarm System Corrective actions for residents affected: No residents were identified. The Director of Plant Operations removed the painted metal plate from the fire alarm control panel on 3/1/11. Identifying other residents having the potential to be affected, and what corrective action will be taken: Residents residing in the center have the potential to be affected. The cover over the fire alarm control panel was removed on 3/1/11.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE 03/21/11

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

Printed: 03/07/2011
FORM APPROVED
OMB NO. 0938-0391

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 03/01/2011	
NAME OF PROVIDER OR SUPPLIER IDAHO FALLS CARE & REHABILITATION CEN		STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHANNING WAY IDAHO FALLS, ID 83404		
(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 051	<p>Continued From page 1 system to an approved central station. 19,3,4, 9.6</p> <p>This Standard is not met as evidenced by: Based on observation, it was determined that the facility failed to ensure the fire alarm system was installed in accordance with NFPA 72. The cover over the fire alarm control panel will prevent notification of visual supervisory signals and could prevent hearing an audible signal. The facility had a census of fifty nine residents. This deficiency affected all residents and staff present on the day of the survey.</p> <p>Findings Included:</p> <p>During the tour of the facility on March 1, 2011 at 10:04 AM, observation of the fire alarm control panel revealed that the panel was covered by a metal plate that was painted the same color as the wall. This was observed and noted by the surveyor and the maintenance supervisor.</p> <p>Actual NFPA 72 Standard 1999 Edition; 1-5.4.3.2.2 Visible and audible supervisory signals and visible indication of their restoration to normal shall be indicated within 90 seconds at the following locations: (1) Control unit (central equipment) for local fire alarm systems (2) Building fire command center for emergency</p>	K 051	<p>Measures and systemic changes to prevent recurrence: The Director of Plant Operations was re-educated on NFPA 72 requirements on 3/17/11. The metal plate was removed on 3/1/11 so the fire panel is displayed in a manner as to be easily viewed in the event of an emergency. No obstructive materials will be placed in front of or over the panel screen.</p> <p>Monitoring Corrective Action for sustained corrections: The Director of Plant Operations or designee will conduct an audit weekly for 3 months to ensure there is no obstruction to the fire alarm control panel. The results of these audits will be reviewed monthly by the administrator or designee during the PI process. Discrepancies will be reported in the PI process for review and recommendations.</p> <p>Completion date: 03/21/2011</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 03/07/2011
FORM APPROVED
OMB NO. 0938-0391

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 03/01/2011
NAME OF PROVIDER OR SUPPLIER IDAHO FALLS CARE & REHABILITATION CEN			STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHANNING WAY IDAHO FALLS, ID 83404		
(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 051	Continued From page 2 voice/alarm communications systems (3) Supervising station location for systems installed in compliance with Chapter 5	K 051			

MAR/18/2011/FRI 04:18 PM

P. 004
PRINTED: 03/07/2011
FORM APPROVED

Bureau of Facility Standards

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 03/01/2011
NAME OF PROVIDER OR SUPPLIER IDAHO FALLS CARE & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHANNING WAY IDAHO FALLS, ID 83404		
(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) COMPLETE DATE
C 000	16.03.02 INITIAL COMMENTS 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. 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. The following deficiencies were cited during the annual Fire Life Safety survey conducted on March 1, 2011. The facility was surveyed under IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities. The surveyor conducting the survey was: Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction	C 000		
C 226	02.106 FIRE AND LIFE SAFETY 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. This Rule is not met as evidenced by:	C 226	See K 051	

RECEIVED
MAR 22 2011
FACILITY STANDARDS

LABORATORY/DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *Interim Administrator* (X5) DATE: *03/21/11*

STATE FORM 02/100 UJW121 If continuation sheet 1 of 2

MAR/18/2011/FRI 04:18 PM

P. 005
PRINTED: 03/01/2011
FORM APPROVED

Bureau of Facility Standards

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 03/01/2011
NAME OF PROVIDER OR SUPPLIER IDAHO FALLS CARE & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3111 CHANNING WAY IDAHO FALLS, ID 83404		
(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) COMPLETE DATE
C 226	Continued From Page 1 Refer to the following Federal "K" tags on the CMS - 2567: 1. K051 Fire alarm panel installation.	C 226		

STATE FORM

021199

UJW121

If continuation sheet 2 of 2