



DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
CONSORTIUM FOR QUALITY IMPROVEMENT AND SURVEY & CERTIFICATION OPERATIONS
WESTERN CONSORTIUM – DIVISION OF SURVEY & CERTIFICATION

IMPORTANT NOTICE - PLEASE READ CAREFULLY

April 5, 2011

Roger Parker, Administrator
Idaho Falls Care and Rehabilitation Center
3111 Channing Way
Idaho Falls, ID 83404

CMS Certification Number: 13-5107

Dear Mr. Parker:

On March 29, 2011, a Life Safety Code survey was completed at Idaho Falls Care and Rehabilitation Center by a survey team from the Centers for Medicare and Medicaid Services (CMS), to determine if the facility was in compliance with federal participation requirements for nursing homes participating in the Medicare/Medicaid programs. This survey found Idaho Falls Care and Rehabilitation Center was not in compliance with these requirements and the most serious deficiencies cited constituted a potential for more than minimal harm to residents.

Plan of Correction (PoC)

The results of this survey are listed on the enclosed Statement of Deficiencies and Plan of Correction (CMS Form 2567). Please provide only one completion date for each Federal Tag, to signify when you allege that each tag will be back in compliance. After each deficiency has been answered and dated, the administrator should sign the CMS Form 2567 and return the originals to this office.

A PoC for the deficiencies cited must be submitted to our office no later than ten calendar days after receipt of the Statement of Deficiencies, Form CMS-2567. The PoC should be submitted by **April 15, 2011**.

The PoC must contain the following:

- What corrective actions 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 will be taken.

Denver Regional Office
1600 Broadway, Suite 700
Denver, CO 80202

San Francisco Regional Office
75 Hawthorne Street, 4th Floor
San Francisco, CA 94105

Seattle Regional Office
2201 Sixth Avenue, RX-48
Seattle, WA 98121

- 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 actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.

The plan of correction (POC) should be addressed to:

**Centers for Medicare and Medicaid Services
Survey, Certification & Enforcement Branch
ATTN: Gary Keopanya
2201 Sixth Avenue, MS RX-48
Seattle, WA 98121
Fax: 206-615-2088**

An Allegation of Compliance

If you believe these deficiencies have been corrected, you may contact the Regional Office (Gary Keopanya) with your written 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.

A Waiver Request

A temporary or continuing waiver for a defined time period may be considered for a deficiency for which corrective action will take more than 90 days to complete. The request for a waiver itself will not delay imposition of long-term enforcement regulations. If a waiver is granted, during that time sanctions will not be imposed. The waiver request documentation submitted for consideration will need to include a timeframe with milestone dates for major activities to correct the deficiency that could be monitored during any subsequent follow-up visits.

During the time period of the waiver, the facility may need to have increased fire safety awareness. This increased fire safety awareness may include the establishment of interim safety measures such as a fire watch during construction, an increased number of fire drills and training of staff at the facility, or other measures that would provide an increased measure of fire protection. The waiver request should include plans to increase fire safety awareness.

The request for a waiver may be addressed to:

**Centers for Medicare and Medicaid Services
Survey, Certification & Enforcement Branch
ATTN: Gary Keopanya
2201 Sixth Avenue, MS RX-48
Seattle, WA 98121**

Informal Dispute Resolution (IDR)

In accordance with 42 CFR 488.33I, you have an opportunity to question cited deficiencies through an IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of substandard quality of care or immediate jeopardy. To be given such an opportunity, you are required to send the written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies or scope and severity. This request must be sent during the same ten calendar days you have for submitting a PoC for the cited deficiencies. An incomplete IDR process will not delay the effective date of any enforcement actions.

The IDR in no way is to be construed as a formal evidentiary hearing. It is an informal administrative process to discuss deficiencies. If counsel will accompany you, you must indicate this in your request for IDR so that we may also have counsel present. You will be advised of our decision relative to the informal dispute through written confirmation.

If you have any questions concerning the instructions contained in this letter, please contact Gary Keopanya at (206) 615-2321.

Sincerely,

Steven Chickering
Associate Regional Administrator, Western Consortium
Division of Survey and Certification

cc: Bureau of Facility Standards – Debby Ransom
Mark Grimes
Idaho State Ombudsman

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

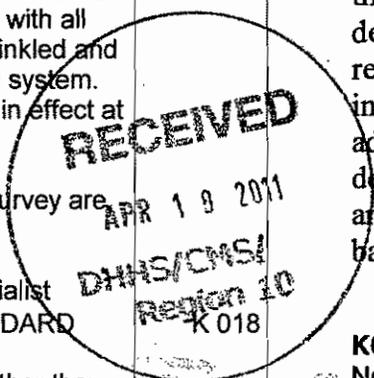
PRINTED: 03/31/2011
FORM APPROVED
OMB NO. 0938-0391

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 03/29/2011
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NAME OF PROVIDER OR SUPPLIER IDAHO FALLS CARE & REHABILITATION CENTER	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>An unannounced Federal Comparative Life Safety Code Survey was conducted at Idaho Falls Care & Rehabilitation Center in Idaho Falls, ID on 3/29/2011 by staff from the Centers for Medicare and Medicaid Services, Seattle, Washington. The 2000 Existing Edition of the Life Safety Code was utilized for this survey, in accordance to 42 Code of Federal Regulations, Part 483.70: Requirements for Long Term Care (LTC) Facilities.</p> <p>The LTC 105 bed facility, census of 51, consisted of a Type V (III) single storied structure with all exits to grade. The structure is fully sprinkled and has an automatic fire and smoke alarm system. There are no Life Safety Code waivers in effect at this time.</p> <p>The deficiencies identified during this survey are listed below.</p> <p>Richard Leland, Life Safety Code Specialist</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>	
K 018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p>	K 018	<p>K018 Life Safety Code Standard</p> <p>No residents were affected. Doors for the kitchen were ordered 04/01/11 by the maintenance director and will be installed when received. Both therapy gym doors had the closure mechanisms adjusted 03/30/11, so they close properly and latch by the maintenance director, along with doors for rooms 302 & 406 adjusted so the doors latch when pulled closed on 03/30/11.</p>	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Rog A [Signature]</i>	TITLE Interim Administrator	(X6) DATE 04/14/11
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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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K 018	Continued From page 1	K 018	The maintenance director made adjustments to the therapy doors and rooms 302 and 406 doors noted as not latching and ordered doors to the kitchen on 04/01/11. The maintenance director also made an audit of the remaining doors on 03/30/11 thru 04/01/11.	
K 038 SS=E	<p>This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to assure that door openings closed to resist the passage of smoke to corridors. This potentially exposed residents to a smoke/fire environment. Findings include:</p> <p>During the facility tour on 3/29/2011 from 9:15 am to 11:00 am observed that the double doors to the Kitchen, PT and OT did not close and latch. Resident Rooms 302 and 406 doors did not close and latch. These findings were acknowledged by the Administrator and Maintenance Supervisor.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility failed to assure that exit accesses are readily accessible to evacuate the facility at all times. This potentially prevents residents from leaving a smoke or fire environment. The findings are as follows:</p>	K 038	<p>The maintenance director was re-educated on the safety need for door latching on 03/30/11. The maintenance director will review doors on monthly PM walk through inspections for proper closure, and managers will note any concerns on their room round documents as they visit rooms through the week.</p> <p>Doors will be monitored by the maintenance director during monthly PM rounds. Administration will make random walk through inspections with the maintenance director for review of doors latching properly. Trends will be reported to the PI committee for review and recommendations for the next three months.</p> <p>4/14/2011</p>	

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K 038 SS=E	<p>This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to assure that door openings closed to resist the passage of smoke to corridors. This potentially exposed residents to a smoke/fire environment. Findings include:</p> <p>During the facility tour on 3/29/2011 from 9:15 am to 11:00 am observed that the double doors to the Kitchen, PT and OT did not close and latch. Resident Rooms 302 and 406 doors did not close and latch. These findings were acknowledged by the Administrator and Maintenance Supervisor.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility failed to assure that exit accesses are readily accessible to evacuate the facility at all times. This potentially prevents residents from leaving a smoke or fire environment. The findings are as follows:</p>	K 038	<p>K038 Life Safety Code Standard No residents were affected by this deficiency. Codes for the doors have been posted at the key pads for visitors to use in case of an emergency by the maintenance director. Bids were received for hard surfacing an egress from the 200/300 emergency exit are to the parking lot in front and submitted to the administrator by the maintenance director. A concrete walkway with ramp will be poured for a safe egress from the building to the front parking lot by the contractor.</p>	

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K 038	Continued From page 2 During the facility tour on 3/29/2011 from 9:15 am to 11:00 am, observed that all exit egress doors were magnetically locked with a key pad to release the lock. None of the key pads had visible codes posted. When asked, the Maintenance Supervisor stated that all the exit doors were configured in this manner and no codes were posted. CMS 's interpretation of NFPA 101, 19.2.2.2.4 and 19.2.2.2.5 requires that all cognitively aware residents, visitors, as well as staff members have a means of opening exit egress doors. During the facility tour on 3/29/11 from 9:15 am to 11:00 am observed that the 200 and 300 corridor exit egresses had no hard surfaced path through the grass to exit the building. These observations were acknowledged by the Administrator and Maintenance Supervisor. When asked, the Maintenance Supervisor stated that snow did accumulate in those areas and was not cleared.	K 038	The maintenance director started bids for the walkway on 03/30/11. The walkway will extend through the courtyard and end at a ramp in the front parking lot. No other egress noted to not have a hard packed surface area. The maintenance director was re-educated on the safety of having a hard surfaced egress on 03/30/11. The maintenance director obtained bids for the pouring of a concrete walkway with a ramp to insure safe and proper egress from the 200/300 courtyard area. All other exits were reviewed by the maintenance director for safe and proper egress to a hard surface and safe area. The administrator will assist in obtaining and forwarding bids for a purchase order to get the hard surface installed. Maintenance will insure monthly that the area(s) are kept free of clutter to allow for a safe egress. Trends will be reported to the PI committee for review and recommendations for the next three months. 4/14/2011		
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain an automatic sprinkler system. This has the potential of having a non-functional sprinkler system that would expose residents to a fire or smoke environment. The findings are as follows:	K 062			

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K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain an automatic sprinkler system. This has the potential of having a non-functional sprinkler system that would expose residents to a fire or smoke environment. The findings are as follows:	K 062	K062 Life Safety Code Standard No residents were affected by this deficiency. Rooms 106, 115, 314 and the 300 corridor housekeeping room have had escutcheons replaced and/or properly seated 04/03/11. All resident rooms and offices were reviewed for escutcheon seating and/or missing escutcheons 04/03/11.	

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K 062	Continued From page 3	K 062		
K 130 SS=D	<p>During the facility tour on 3/29/2011 from 9:15 am to 11:00 am observed that there were sprinkler head escutcheons missing or dropped out of position in Residents ' Rooms 106, 115, 314 and the 300 corridor Housekeeping Room. These findings were acknowledged by the Maintenance Supervisor.</p> <p>NFPA 101 MISCELLANEOUS</p> <p>OTHER LSC DEFICIENCY NOT ON 2786</p> <p>This STANDARD is not met as evidenced by: Based on observations and staff interview the facility failed to maintain non-patient gas storage in accordance to NFPA 99, 8-5.2.1.1. This has the potential for the compressed gas cylinders to be damaged and expelling gas at a high rate which could inflict harm on staff or residents.</p> <p>During the facility tour on 3/29/2011, from 9:15 am to 11:00 am, observed three Carbon Dioxide cylinders used for the soda machine unsecured in the Employee Break Room. This observation was acknowledged by the Maintenance Supervisor.</p>	K 130	<p>The maintenance director was re-educated on escutcheon placement 03/30/11. Escutcheons were ordered 03/30/11 to insure adequate supply was available to replace any others noted missing. Appropriate hardware will be placed around the sprinkler heads and any repairs made will be reviewed by the administrator and maintenance director for code compliance. All rooms have been reviewed for proper placement of escutcheons. Those noted missing have been replaced and those noted as improperly placed have been seated correctly. The maintenance director will add review for escutcheons in the monthly PM of the sprinkler system.</p> <p>Managers will report any discrepancies with escutcheons that are noticed during their room monitoring. The administrator and director of maintenance will make rounds at least twice a month to insure sprinkler heads have proper hardware in place. The maintenance director will review escutcheons during PM rounds to insure they are in place and properly seated. Trends will be reported to the PI process for review and recommendations for the next three months.</p> <p>4/14/2011</p>	
K 147 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to assure that approved wiring was maintained per NFPA Standard: NFPA 70, Article</p>	K 147		

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K 130 SS=D	<p>During the facility tour on 3/29/2011 from 9:15 am to 11:00 am observed that there were sprinkler head escutcheons missing or dropped out of position in Residents ' Rooms 106, 115, 314 and the 300 corridor Housekeeping Room. These findings were acknowledged by the Maintenance Supervisor.</p> <p>NFPA 101 MISCELLANEOUS</p> <p>OTHER LSC DEFICIENCY NOT ON 2786</p> <p>This STANDARD is not met as evidenced by: Based on observations and staff interview the facility failed to maintain non-patient gas storage in accordance to NFPA 99, 8-5.2.1.1. This has the potential for the compressed gas cylinders to be damaged and expelling gas at a high rate which could inflict harm on staff or residents.</p>	K 130	<p>K130 Life Safety Code Standard No residents were affected by this deficiency. The carbon dioxide tanks were secured with a chain attached to the wall 03/30/11 by the maintenance director.</p> <p>The maintenance director completed an audit on 03/30/11 and noted no other area as having unsecured portable gas tanks.</p> <p>The maintenance director was educated on storage of compressed gas cylinders 03/30/11. Appropriate hardware was placed around the cylinders 03/30/11 by the maintenance director and reviewed by the administrator and maintenance director for code compliance. The maintenance director will check after each visit from the drink vendor to insure chains are properly placed and secured.</p>	
K 147 SS=D	<p>During the facility tour on 3/29/2011, from 9:15 am to 11:00 am, observed three Carbon Dioxide cylinders used for the soda machine unsecured in the Employee Break Room. This observation was acknowledged by the Maintenance Supervisor.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to assure that approved wiring was maintained per NFPA Standard: NFPA 70, Article</p>	K 147	<p>The administrator and director of maintenance will make rounds at least twice a month to insure the cylinders are securely fastened. The maintenance director will review monthly during PM rounds to insure the canisters are properly secured. Trends will be reported to the PI committee for review and recommendations for the next three months.</p> <p>4/14/2011</p>	

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K 147	<p>Continued From page 4</p> <p>400-8. Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used as a substitute for the fixed wiring of a structure. CMS Manual System, Pub. 100-07 State Operations, Provider Certification; August 17, 2007. Power strips may not be used as a substitute for adequate electrical outlets in a facility. Power strips may be used for a computer, monitor, and printer. Power strips are not designed to be used with medical devices in patient care areas. Precautions needed if power strips are used include: installing internal ground fault and over-current protection devices; preventing cords from becoming tripping hazards; and using power strips that are adequate for the number and types of devices used. Overload on any circuit can potentially cause overheating and fire. The use of ground fault circuit interruption (GFCIs) may be required in locations near water sources to prevent electrocution of staff or residents. This potentially exposed residents to electrical fire hazard caused by overloaded circuits. Findings include:</p> <p>During the facility tour on 3/29/11 from 9:15 am to 11:00 am, observed in Resident Rooms 207 and 215 flexible power taps with electrical devices plugged in them. In the TV Lounge Room behind the aquarium observed two power strips piggybacked together with five cords plugged into the strips. These observations were acknowledged by the Maintenance Supervisor.</p>	K 147	<p>K147 Life Safety Code Standard No residents were affected by this deficiency. All noted cords were removed by the maintenance director immediately on 04/29/11.</p> <p>Maintenance rounds were made on 04/07/11 by the maintenance director to identify and remove other cords.</p> <p>Administrator re-educated department supervisors and the maintenance director on 04/30/11 that no type extension cord/power strip can be utilized in a resident care area. Managers will also check for use of cords/strips during their room rounds.</p> <p>Resident rooms will be checked during PM rounds by the maintenance director to insure no extension cords/power strips are used in the resident care areas. Trends will be reported to the PI committee for review and recommendations for the next three months.</p> <p>4/14/2011</p>	