



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

IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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P.O. Box 83720  
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**CERTIFIED MAIL: 7007 3020 0001 4044 7311**

April 11, 2013

Michael E. Borup, Administrator  
Quinn Meadows Rehabilitation & Care Center  
1033 West Quinn Road  
Pocatello, ID 83202-2425

Provider #: 135136

Dear Mr. Borup:

On **April 1, 2013**, a Facility Fire Safety and Construction survey was conducted at **Quinn Meadows Rehabilitation & Care 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, and a similar State 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 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 both

Michael E. Borup, Administrator  
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Statement of Deficiencies and Plan of Correction, Form CMS-2567 and State Form, in the spaces provided and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **April 24, 2013**. Failure to submit an acceptable PoC by **April 24, 2013**, may result in the imposition of civil monetary penalties by **May 14, 2013**.

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 **May 6, 2013**, (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **May 6, 2013**.

A change in the seriousness of the deficiencies on **May 6, 2013**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **May 6, 2013**, includes the following:

Denial of payment for new admissions effective **July 1, 2013**.  
42 CFR §488.417(a)

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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 **October 1, 2013**, 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 Mark P. Grimes, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, 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 **April 1, 2013**, 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://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

Go to the middle of the page to Information Letters section and click on State and select the following:

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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 **April 24, 2013**. If your request for informal dispute resolution is received after **April 24, 2013**, 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,

A handwritten signature in black ink, appearing to read 'M. Grimes', followed by a long horizontal flourish line extending to the right.

Mark P. Grimes, Supervisor  
Facility Fire Safety and Construction

MPG/dmj

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

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135136</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - QUINN MEADOWS</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/01/2013</b>
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NAME OF PROVIDER OR SUPPLIER <b>QUINN MEADOWS REHABILITATION &amp; CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1033 WEST QUINN ROAD POCATELLO, ID 83202</b>
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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><b>INITIAL COMMENTS</b></p> <p>The facility is approximately 26,000 square foot of type V (111) construction subdivided into two smoke compartments, there is an attached Physical Therapy office separated by two hour construction. The building is sprinklered with corridor smoke detection and manual fire alarm system. Emergency power is provided by an onsite generator system. The facility is currently licensed for 41 beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on April 18, 2012. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, New Health Care Occupancy, in accordance with 42 CFR, 483.70.</p> <p>The surveyor conducting the survey was:</p> <p>Tom Mroz, CFI-II Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000	<p><i>Preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the accuracy of the truthfulness of any facts alleged or any conclusions set forth in this allegation of deficiencies by the State Licensing Authority.</i></p> <p><i>Accordingly, the facility has drafted this Plan of Correction in accordance with the Federal and State Laws which mandate the submission of a Plan of Correction shall constitute this facility's credible allegation of compliance with this section.</i></p>	
K 025 SS=F	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Smoke barriers are constructed to provide at least a one-hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels in approved frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3, 18.3.7.5, 18.1.6.3</p>	K 025	<p><b>K025</b></p> <p><b>Specific Residents</b></p> <p>No residents were affected by this practice. The penetrations beneath the kitchen hand sink, in the mechanical room where the dryer exhaust vent passes through the ceiling and the penetration in the maintenance office have been filled with a material and or an approved device that is capable of maintaining the smoke resistance of the smoke barrier.</p>	05/06/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <b>ADMINISTRATOR</b>	(X6) DATE <b>4/22/13</b>
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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 025	<p>Continued From page 1</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to assure that all smoke barriers would provide protection against passage of smoke. This potentially exposed residents to a smoke or fire environment. This deficient practice affected staff and 15 residents in one of two smoke compartments. The facility has the capacity for 41 beds with a census of 26 the day of survey.</p> <p>Findings include:</p> <p>1.) During the facility tour on 04/01/13 at 1:55 p.m., it was observed that beneath the kitchen hand sink was an approximately 1" open penetration in the annular space around the water supply line that would allow the passage of smoke in the event of a fire. Interview with the facility Maintenance Supervisor on 04/01/13 at 1:55 p.m., revealed the facility was unaware of the open penetration.</p> <p>2.) During the facility tour on 04/01/13 at 2:12 p.m., it was observed that in the mechanical room opposite the kitchen there was an approximately 4" open penetration in the annular space where the dryer exhaust vent passed through the ceiling that would allow the passage of smoke in the event of a fire. Interview with the facility Maintenance Supervisor on 04/01/13 at 2:12 p.m., revealed the facility was unaware of the open penetration.</p> <p>3.) During the facility tour on 04/01/13 at 2:31 p.m., it was observed that the maintenance office had an approximately 4" x 4" wall penetration with wires passing through it that would allow the passage of smoke in the event of a fire. Interview</p>	K 025	<p><b>All Residents</b></p> <p>All residents have the potential to be affected by this practice. All penetrations and miscellaneous openings in floors and smoke barriers shall meet one of the following conditions:</p> <ol style="list-style-type: none"> <li>a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier.</li> <li>b. It shall be protected by an approved device that is designed for the specific purpose.</li> </ol> <p><b>Systemic Changes</b></p> <p>The Maintenance Director or designee will at a minimum do monthly checks throughout the facility to validate that all penetrations and miscellaneous openings in floors and smoke barriers shall meet one of the following conditions:</p> <ol style="list-style-type: none"> <li>a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier.</li> </ol>	

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K 025	<p>Continued From page 2 with the facility Maintenance Supervisor on 04/01/13 at 2:31 p.m., revealed the facility was unaware of the open penetration.</p> <p>The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 04/01/13.</p> <p>Actual NFPA Standard: 8.3.6 Penetrations and Miscellaneous Openings in Floors and Smoke Barriers. 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (1) The space between the penetrating item and the smoke barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose.</p>	K 025	<p><b>K025 Continued</b></p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>Repairs will be conducted as needed if penetrations and miscellaneous openings in floors and smoke barriers are found.</p> <p><b>Monitoring</b></p> <p>The Maintenance Director or designee will discuss findings with the Administrator. The Administrator will follow up as necessary to validate compliance. Results of monitoring will also be discussed in quarterly CQI meeting. The decision to continue or discontinue monitoring will be addressed in the quarterly CQI meeting. Monitoring will start the week of April 29, 2013.</p>	
K 052 SS=F	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility</p>	K 052	<p><b>K052</b></p> <p><b>Specific Residents</b></p> <p>No residents were harmed from this practice.</p>	05/06/13

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K 052	<p>Continued From page 3</p> <p>failed to provide a smoke detector above the fire alarm power supply panel located in the data equipment room. Lack of smoke detection may cause the fire alarm power supply panel to be incapacitated by fire before a detection device responded. The deficient practice would affect all smoke compartments, all residents, visitors, and staff of the facility. The facility has the capacity for 41 licensed beds with a census of 26 on the day of the survey.</p> <p>Findings include:</p> <p>Observation of the data equipment room on 04/01/13 at 2:20 p.m., the facility failed to provide automatic smoke detection at the fire alarm power supply panel. Interview with the facility Maintenance Supervisor on 04/01/13 at 2:20 p.m., indicated the facility was not aware that smoke detection was required at this location.</p> <p>The finding was acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 04/01/13.</p> <p>Actual NFPA standard: NFPA 72 1-5.6 Protection of Fire Alarm Control Unit(s).</p> <p>In areas that are not continuously occupied, automatic smoke detection shall be provided at the location of each fire alarm control unit(s) to provide notification of fire at that location.</p> <p>Exception: Where ambient conditions prohibit installation of automatic smoke detection, automatic heat detection shall be permitted.</p>	K 052	<p><b>K052 Continued</b></p> <p><b>All Residents</b></p> <p>All residents have a potential to be affected by this practice. The data equipment room has been equipped with a smoke detector above the fire alarm power supply panel located in the data equipment room.</p> <p><b>Systemic</b></p> <p>Maintenance Director or designee will conduct at a minimum quarterly checks to validate that automatic smoke detectors are provided at the location of each fire alarm control unit(s) to provide notification of fire at that location.</p> <p><b>Monitoring</b></p> <p>Maintenance Director will report any out of compliance findings to the Administrator. Administrator will validate compliance. Results of monitoring will also be discussed in quarterly CQI meeting. The decision to continue or discontinue monitoring will be addressed in the quarterly CQI meeting. Monitoring will start the week of April 29, 2013.</p>	
K 056 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the</p>	K 056	<p><b>K056 Continued on next page</b></p>	05/06/13

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K 056	<p>Continued From page 4</p> <p>Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5.</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to provide complete coverage by the automatic sprinkler system as required for a Type V (111) protected, ordinary construction. The deficient practice affected two of two smoke compartments, staff, and all residents. The facility has the capacity for 41 beds with a census of 26 the day of survey.</p> <p>Findings include:</p> <p>1.) Observation on 04/01/13 at 2:19 p.m., revealed that sprinkler coverage was not provided for the attached combustible overhang at the 100 hall northeast exit. The overhang was approximately six feet by five feet in dimension. Interview with the Maintenance Supervisor on 04/01/13 at 2:19 p.m., revealed that the facility was not aware that the attached combustible overhang was not provided with sprinkler protection.</p> <p>2.) Observation on 04/01/13 at 2:38 p.m.,</p>	K 056	<p><b>K056</b></p> <p><b>Specific Residents</b></p> <p>No residents were affected by this practice.</p> <p><b>All Residents</b></p> <p>This practice has the potential to affect all residents. The facility has provided complete coverage by the automatic sprinkler system as required for a Type V (111) protected, ordinary construction. The two smoke compartments affected have had sprinkler heads placed in the attached combustible overhangs.</p> <p><b>Systemic Changes</b></p> <p>An inspection will be completed of the facility by an approved fire protection company to validate that fire system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. In-service will be provided to the Maintenance Director by the approved fire protection company to assist the Maintenance Director in making monthly compliance checks.</p>		

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K 056	<p>Continued From page 5</p> <p>revealed that sprinkler coverage was not provided for the attached combustible overhang at the 300 hall northwest exit. The overhang was approximately six feet by five feet in dimension. Interview with the Maintenance Supervisor on 04/01/13 at 2:38 p.m., revealed that the facility was not aware that the attached combustible overhang was not provided with sprinkler protection.</p> <p>The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 04/01/13.</p> <p>Actual NFPA Standards: NFPA 101, 18.3.5.1 Buildings containing health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7</p> <p>NFPA 101, 9.7.1 Automatic Sprinklers. 9.7.1.1 Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.</p> <p>NFPA 13, 5-13.8.1. Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft. (1.2 m) in width.</p>	K 056	<p><b>K056 Continued</b></p> <p><b>Monitoring</b></p> <p>Maintenance will discuss any new findings to the Administrator after completion of monthly compliance rounds. Administrator will validate compliance. Results of monitoring will also be discussed in quarterly CQI meeting. The decision to continue or discontinue monitoring will be addressed in the quarterly CQI meeting. Monitoring will start the week of April 29, 2013.</p>		
K 144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p>	K 144	<p><b>K144</b></p> <p><b>Specific Residents</b></p> <p>No residents were affected because of this practice.</p>	05/06/13	

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K 144	<p>Continued From page 6</p> <p>This Standard is not met as evidenced by: Based on observation and interview, the facility failed to provide a remote generator annunciator in a continuously monitored location where it would likely be heard by. This potentially exposed residents to loss of illumination of exit egress, fire and smoke alarms, and life support equipment during power outage. The deficient practice affected two of two smoke compartments, staff, and 26 residents. The facility has the capacity for 41 beds with a census of 26 the day of survey.</p> <p>Findings include:</p> <p>Observation on 04/01/13 at 2:05 p.m., revealed that the generator remote annunciator panel is located in an unoccupied mechanical room opposite the kitchen. The mechanical room is not a continuously monitored location. Interview on 04/01/13 at 2:05 p.m., with the Maintenance Supervisor revealed the facility was not aware of the requirement for the generator remote annunciator panel to be located where it is continuously monitored.</p> <p>The finding was acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 04/01/13.</p> <p>Actual NFPA Standard: NFPA 99, 3-4.1.1.15 Alarm Annunciator. A remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see</p>	K 144	<p><b>K144 Continued</b></p> <p><b>All Residents</b></p> <p>All residents have the potential to be affected by this practice. A remote generator annunciator panel has been placed in the area of the nurse's station. The remote generator annunciator panel is in compliance with NFPA 70, National Electrical Code, Section 700-12.</p> <p>The annunciator indicates alarm conditions of the emergency or auxiliary power source as follows:</p> <p>(a) Individual visual signals that indicate the following:</p> <ol style="list-style-type: none"> <li>1. When the emergency or auxiliary power source is operating to supply power to load</li> <li>2. When the battery charger is malfunctioning</li> </ol> <p>(b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following:</p> <ol style="list-style-type: none"> <li>1. Low lubrication oil pressure</li> <li>2. Low water temperature (below those required in 3-4.1.1.9)</li> </ol>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135136</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - <b>QUINN MEADOWS</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/01/2013</b>
NAME OF PROVIDER OR SUPPLIER <b>QUINN MEADOWS REHABILITATION &amp; CARE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1033 WEST QUINN ROAD POCATELLO, ID 83202</b>		
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K 144	Continued From page 7 NFPA 70, National Electrical Code, Section 700-12.) The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: (a) Individual visual signals shall indicate the following: 1. When the emergency or auxiliary power source is operating to supply power to load 2. When the battery charger is malfunctioning (b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following: 1. Low lubricating oil pressure 2. Low water temperature (below those required in 3-4.1.1.9) 3. Excessive water temperature 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply 5. Overcrank (failed to start) 6. Overspeed Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur, but need not display these conditions individually. [110: 3-5.5.2]	K 144	<b>K144 Continued</b>  3. Excessive water temperature  4. Low fuel – when the main fuel storage tank contains less than a 3-hour operating supply  5. Overcrank (failed to start)  6. Overspeed  <b>Systemic Changes</b>  Maintenance Director or designee will on a monthly basis validate that the remote generator annunciator panel is working in compliance to NFPA 99, 3-4.1.1.15.  <b>Monitoring</b>  Maintenance will discuss any new findings to the Administrator after completion of monthly compliance rounds. Administrator will validate compliance. Results of monitoring will also be discussed in quarterly CQI meeting. The decision to continue or discontinue monitoring will be addressed in the quarterly CQI meeting. Monitoring will start the week of April 29, 2013.  <b>K147 Continued on next page</b>	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2  This Standard is not met as evidenced by: Based on observation and interview, the facility failed to ensure electric circuit breaker(s) were labeled. This potentially exposed residents to	K 147		

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

Printed: 04/08/2013  
FORM APPROVED  
OMB NO. 0938-0391

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K 147	<p>Continued From page 8</p> <p>electrical fire hazard. This deficient practice affected staff and 15 residents in one of two smoke compartments. The facility has the capacity for 41 beds with a census of 26 the day of survey.</p> <p>Findings include:</p> <p>Observation on 04/01/13 at 2:33 p.m., of the Maintenance Supervisors office revealed the circuit breakers in Panel SE1 were not labeled as to what they control. Interview with the facility Maintenance Supervisor on 04/01/13 at 2:33 p.m., indicated the facility was not aware that the circuits were not labeled.</p> <p>The finding was acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 04/01/13.</p> <p>Actual NFPA standard: NFPA 70 10.22 Identification of Disconnecting Means.</p> <p>Each disconnecting means shall be legibly marked to indicate its purpose unless located and arranged so the purpose is evident. The marking shall be of sufficient durability to withstand the environment involved.</p>	K 147	<p><b>K147</b></p> <p><b>Specific Residents</b></p> <p>No residents were affected because of this practice.</p> <p><b>All Residents</b></p> <p>All residents have the potential to be affected by this practice. All circuit breakers in Panel SE1 have been labeled in accordance with NFPA 70.10.22. All other circuit panels within the facility have been labeled in accordance NFPA 70.10.22.</p> <p><b>Systemic Changes</b></p> <p>Maintenance Director or designee will on a monthly basis validate compliance with NFPA 70.10.22.</p> <p><b>Monitoring</b></p> <p>Maintenance Director or designee will discuss any out of compliance findings with regards to NFPA 70.10.22. Administrator will validate compliance. Results of monitoring will also be discussed in quarterly CQI meeting. The decision to continue or discontinue monitoring will be addressed in the quarterly CQI meeting. Monitoring will start the week of April 29, 2013.</p>	05/06/13

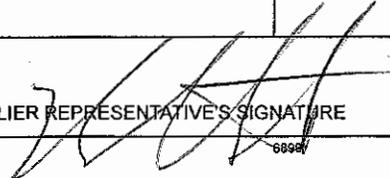
Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001635</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01 - QUINN MEADOWS</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/01/2013</b>
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C 000	<p><b>16.03.02 INITIAL COMMENTS</b></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 approximately 26,300 square foot of type V (111) construction subdivided into two smoke compartments, there is an attached Physical Therapy office separated by two hour construction. The building is sprinklered with corridor smoke detection and manual fire alarm system. Emergency power is provided by an onsite generator system. The facility is currently licensed for 41 beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on April 18, 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>Tom Mroz, CFI-II Health Facility Surveyor Facility Fire Safety and Construction</p>	C 000	<p><i>Preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the accuracy of the truthfulness of any facts alleged or any conclusions set forth in this allegation of deficiencies by the State Licensing Authority.</i></p> <p><i>Accordingly, the facility has drafted this Plan of Correction in accordance with the Federal and State Laws which mandate the submission of a Plan of Correction shall constitute this facility's credible allegation of compliance with this section.</i></p>	
C 226	<p><b>02.106 FIRE AND LIFE SAFETY</b></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. This Rule is not met as evidenced by: Refer to the following Federal "K" tags on the CMS - 2567:</p>	C 226	<p><b>RECEIVED</b></p> <p>APR 23 2013</p> <p><b>FACILITY STANDARDS</b></p>	

Bureau of Facility Standards

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

STATE FORM



TITLE

*Administrator*

(X6) DATE

*4/22/13*

BCIW21

If continuation sheet 1 of 2

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001635</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01 - QUINN MEADOWS</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/01/2013</b>
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C 226	Continued From page 1  1.) K025 Penetrations  2.) K052 Fire Alarm System  3.) K056 Unsprinklered Areas  4.) K144 Generator Annunciator Panel  5.) K147 Circuits Not Labeled	C 226	Please see K025  Please see K052  Please see K056  Please see K144  Please see K147	05/06/13