



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
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CERTIFIED MAIL: 7012 1010 0002 0836 4070

July 10, 2014

Arthur Gulden, Administrator
Bingham Memorial Skilled Nursing & Rehabilitation
98 Poplar Street
Blackfoot, ID 83221-1758

Provider #: 135007

**RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER
LETTER**

Dear Mr. Gulden:

On **June 30, 2014**, a Facility Fire Safety and Construction survey was conducted at **Bingham Memorial Skilled Nursing & Rehabilitation** 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 an isolated 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

Arthur Gulden, Administrator
July 10, 2014
Page 2 of 4

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 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 **July 23, 2014**. Failure to submit an acceptable PoC by **July 23, 2014**, may result in the imposition of civil monetary penalties by **August 12, 2014**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.
- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567 and the state licensure survey report, State Form.

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 **August 4, 2014**, (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 **August 4, 2014**. A change in the seriousness of the deficiencies on **August 4, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by

Arthur Gulden, Administrator
July 10, 2014
Page 3 of 4

August 4, 2014, includes the following:

Denial of payment for new admissions effective **September 30, 2014**.
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 **December 30, 2014**, 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 **June 30, 2014**, 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/NursingFa>

Arthur Gulden, Administrator
July 10, 2014
Page 4 of 4

[ilities/tabid/434/Default.aspx](#)

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

BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by **July 23, 2014**. If your request for informal dispute resolution is received after **July 23, 2014**, 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 'MPG', followed by a long horizontal line extending to the right.

Mark P. Grimes, Supervisor
Facility Fire Safety and Construction

MPG/lj
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135007	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE NF B. WING _____	(X3) DATE SURVEY COMPLETED 06/30/2014
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NAME OF PROVIDER OR SUPPLIER BINGHAM MEMORIAL SKILLED NURSING & R	STREET ADDRESS, CITY, STATE, ZIP CODE 98 POPLAR STREET BLACKFOOT, ID 83221
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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	INITIAL COMMENTS	K 000		
K 012 SS=D	<p>The facility is a single story, type V (III) structure with a two hour fire wall to the JCAHO accredited hospital. The facility was originally built in 1963 with renovation and addition in 1999. The building is fully sprinklered and is licensed for 70 beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on June 30, 2014. 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>Dan Holbrook Health Facility Surveyor Facility Fire Safety and Construction</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1</p> <p>This Standard is not met as evidenced by: Based on observation the facility failed to protect smoke partitions from penetrations. This deficient practice will allow products of combustion to pass from one compartment to another. This deficiency affected five residents, staff, and visitors. The facility is licensed for 70 beds and had a census of 36 the day of survey.</p> <p>Findings include:</p> <p>1. Observation of the two hour fire barrier above</p>	K 012	<p>The following Plan of Correction is submitted by the facility in accordance with the pertinent terms and provisions of 42 CFR Section 488 and/or related state regulations, and is intended to serve as a credible allegation of our intent to correct the practices identified as deficient. The Plan of Correction should not be construed or interpreted as an admission that the deficiencies alleged did, in fact, exist; rather, the facility is filing this document in order to comply with its obligations as a provider participating in the Medicare/Medicaid program(s).</p> <p style="text-align: center;">RECEIVED JUL 23 2014</p> <p>K 012 FACILITY STANDARDS</p> <p>Corrective action for residents found to have been affected by this deficiency:</p> <p>All firewall penetrations observed during survey have been sealed.</p> <p>Corrective action for residents that may be affected by this deficiency:</p> <p>All residents have the potential to be affected by these identified concerns.</p> <p>All firewall penetrations observed during survey have been sealed.</p> <p>Full facility audit completed to ensure any other instances of firewall penetrations were sealed.</p> <p>In-service will be given to engineering and IT staff regarding firewall integrity by 8/1/14</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE - 7/21/14
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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.

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

Printed: 07/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135007	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE NF B. WING _____	(X3) DATE SURVEY COMPLETED 06/30/2014	
NAME OF PROVIDER OR SUPPLIER BINGHAM MEMORIAL SKILLED NURSING & R		STREET ADDRESS, CITY, STATE, ZIP CODE 98 POPLAR STREET BLACKFOOT, ID 83221		
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K 012	Continued From page 1	K 012		
	<p>the 500 hallway ceiling on June 30, 2014 at 2:05 pm revealed two penetrations. One was approximately three by five inches with low voltage cable going through it and a second was approximately one inch in diameter around a conduit pipe. The Director of Engineering and the Lead Maintenance Technician witnessed and acknowledged this finding.</p> <p>2. Observation on June 30, 2014 at 2:10 pm revealed penetrations in the house keeping closet wall around a water drain line and a water supply line. The Director of Engineering and the Lead Maintenance Technician witnessed and acknowledged this finding.</p> <p>3. Observation of the dialysis reverse osmosis water room on June 30, 2014 at 2:40 pm revealed penetrations of various sizes in the ceiling around piping. The Director of Engineering and the Lead Maintenance Technician witnessed and acknowledged this finding.</p> <p>4. Observation of resident room #304 on June 30, 2014 at 2:50 pm revealed a fire sprinkler head without an escutcheon. This revealed a hole in the ceiling around the pipe. The Director of Engineering and the Lead Maintenance Technician witnessed and acknowledged this finding.</p> <p>Actual Reference:</p> <p>NFPA 101</p> <p>8-2.4.4 Penetrations and Miscellaneous Openings in Smoke Partitions. 8.2.4.4.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar</p>		<p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>Director of Engineering or Administrator will complete spot check audit in 5 areas of the facility to examine firewalls for a period of at least 8 weeks beginning the week of 7/27/14. Any issues will be reported to the Safety Committee.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>The Safety Committee will review any issues uncovered by weekly audits and after the initial 8 weeks make a determination related to changing the frequency of those audits. Additionally, Safety Committee will review facility progress on firewall penetrations on an on-going basis to aid in monitoring compliance.</p>	8/4/14

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K 012	Continued From page 2	K 012	
K 027 SS=D	<p>building service equipment that pass through smoke partitions shall be protected as follows: (1) The space between the penetrating item and the smoke partition shall meet one of the following conditions: a. It shall be filled with a material that is capable of limiting the transfer of smoke. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the smoke partition, the sleeve shall be solidly set in the smoke partition, and the space between the item and the sleeve shall meet one of the following conditions: a. It shall be filled with a material that is capable of limiting the transfer of smoke. b. It shall be protected by an approved device that is designed for the specific purpose. (3) Where designs take transmission of vibrations into consideration, any vibration isolation shall meet one of the following conditions: a. It shall be made on either side of the smoke partitions. b. It shall be made by an approved device that is designed for the specific purpose.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p>	K 027	<p><u>K 027</u></p> <p>Corrective action for residents found to have been affected by this deficiency:</p> <p>500 hall door was fixed and able to fully close prior to the end of survey.</p> <p>Corrective action for residents that may be affected by this deficiency:</p> <p>All residents have the potential to be affected by these identified concerns.</p>

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K 027	Continued From page 3	K 027		
	<p>This Standard is not met as evidenced by: Based on observation and operational testing the facility failed to maintain smoke compartment doors. Failure to maintain smoke compartment doors may result in the products of combustion to pass from one compartment to another. This deficiency affected 4 residents, staff, and visitors. The facility is licensed for 70 beds and had a census of 36 the day of survey.</p> <p>Findings include:</p> <p>Observation and operational testing of the 500 hallway cross corridor doors on June 30, 2014 at 1:50 pm revealed one of two doors would swing approximately 85 degrees but failed to fully close. When forced to close the center smoke seal failed to engage fully due to apparent misalignment. The Director of Engineering and the Lead Maintenance Technician witnessed and acknowledged this finding.</p> <p>NFPA 101</p> <p>19.2.2.2.6*</p> <p>Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier, or hazardous area enclosure shall be permitted to be held open only by an automatic release device that complies with 7.2.1.8.2. The automatic sprinkler system, if provided, and the fire alarm system, and the systems required by 7.2.1.8.2 shall be arranged to initiate the closing action of all such doors throughout the smoke compartment or throughout the entire facility.</p>		<p>500 hall door was fixed and able to fully close prior to the end of survey.</p> <p>Full facility audit completed to ensure all other corridor doors sealed properly.</p> <p>In-service will be provided engineering department regarding the need for all corridor doors to seal properly by 8/1/14.</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>Director of Engineering or Administrator will audit at least 3 corridor doors weekly for a period of at least 8 weeks starting the week of 7/27/14 to ensure they seal properly. Any issues will be reported to the Safety Committee.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>The Safety Committee will review any issues uncovered by weekly audits and after the initial 8 weeks make a determination related to changing the frequency of those audits. Additionally, Safety Committee will review facility progress on corridor doors sealing on an on-going basis to aid in monitoring compliance</p>	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour	K 029		8/4/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135007	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE NF B. WING _____	(X3) DATE SURVEY COMPLETED 06/30/2014
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K 029	Continued From page 4 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 This Standard is not met as evidenced by: Based on observation and operational testing the facility failed to maintain hazardous area doors. Failure to maintain hazardous area doors may result in the products of combustion to pass from one compartment to another. This deficiency affected no residents, staff, and visitors. The facility is licensed for 70 beds and had a census of 36 the day of survey. Findings include: Observation on June 30, 2014 at 3:15 pm of the basement pediatric storeroom revealed a fire sprinkled resident shower room greater than 50 square feet converted to storage with free standing metal shelving units lining all walls. Each shelf was filled with plastic children's toys. The corridor door did not have a self closing device. The Director of Engineering and the Lead Maintenance Technician witnessed and acknowledged this finding. Actual NFPA reference 19.3.2.1 Hazardous Areas.	K 029	K 029 Corrective action for residents found to have been affected by this deficiency: Pediatric storeroom corridor door given a self-closing device and door was tested and found to be working properly. Corrective action for residents that may be affected by this deficiency: All residents have the potential to be affected by these identified concerns. Pediatric storeroom corridor door given a self-closing device and door was tested and found to be working properly. Full facility audit completed to ensure all required doors had a self-closing device. In-service provided to Engineering department about self-closing doors prior to 8/1/14 Measures that will be put into place to ensure that this deficiency does not recur: Director of Engineering or Administrator will audit at least 3 doorways requiring self-closing devices weekly for a period of at least 8 weeks starting the week of 7/27/14 to ensure self-closing device is in place and working properly. Any issues will be reported to the Safety Committee. Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135007	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE NF B. WING _____		(X3) DATE SURVEY COMPLETED 06/30/2014
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K 029	Continued From page 5	K 029			
K 070 SS=D	<p>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:</p> <ol style="list-style-type: none"> (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft² (9.3 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. <p>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.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p>	K 070	<p>The Safety Committee will review any issues uncovered by weekly audits and after the initial 8 weeks make a determination related to changing the frequency of those audits. Additionally, Safety Committee will review facility progress on corridor doors and self-closing devices on an on-going basis to aid in monitoring compliance.</p> <p>K 070</p> <p>Corrective action for residents found to have been affected by this deficiency:</p> <p>Portable heater removed from facility prior to end of survey</p>	8/4/14	

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K 070	Continued From page 6	K 070		
K 147 SS=D	<p>This Standard is not met as evidenced by: Based on observation and interview the facility failed to monitor for prohibited portable heating devices. Operation of prohibited portable heating devices risks starting a fire. This deficiency affected 4 residents, staff, and visitors. The facility is licensed for 70 beds and had a census of 36 the day of survey.</p> <p>Findings include:</p> <p>Observation of the speech therapy office in the 500 hallway on June 30, 2014 at 2:25 pm revealed a portable heating device plugged in and under a desk. Director of Maintenance stated they have a policy prohibiting portable heaters and did not know this heater was on the premises. The Director of Engineering and the Lead Maintenance Technician witnessed and acknowledged this finding.</p> <p>Actual NFPA reference:</p> <p>19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies.</p> <p>Exception: Portable space-heating devices shall be permitted to be used in nonsleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C).</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>	K 147	<p>Corrective action for residents that may be affected by this deficiency:</p> <p>All residents have the potential to be affected by these identified concerns.</p> <p>Portable heater removed from facility prior to end of survey</p> <p>Facility inspection done and no other portable heaters were found</p> <p>In-service will be provided to SNRC staff prior to 8/1/14 regarding portable heaters</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>Director of Engineering or Administrator will audit 5 rooms and/or offices weekly for a period of at least 8 weeks beginning the week of 7/27/14 to ensure no portable heaters are present. Any issues will be reported to the Safety Committee.</p> <p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>The Safety Committee will review any issues uncovered by weekly audits and after the initial 8 weeks make a determination related to changing the frequency of those audits. Additionally, Safety Committee will review facility progress on maintaining a portable heater free environment on an on-going basis to aid in monitoring compliance.</p>	8/4/14

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K 147	Continued From page 7	K 147		
	<p>This Standard is not met as evidenced by: Based on observation the facility failed to comply with the National Electrical Code. Failure to comply with the National Electrical Code can result in electric shock and starting a fire. This deficiency affected four residents, staff, and visitors. The facility is licensed for 70 beds and had a census of 36 the day of survey.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Observation of the electrical panel in the 500 hallway on June 30, 2014 at 2:20 pm revealed over half of the circuit breaker devices were unlabeled as to use. The Director of Engineering and the Lead Maintenance Technician witnessed and acknowledged this finding. 2. On June 30, 2014 at 2:40 pm observation of the dialysis reverse osmosis water room revealed two electrical junction boxes without covers in one wall. The Director of Engineering and the Lead Maintenance Technician witnessed and acknowledged this finding. 3. At 3:30 pm on June 30, 2014 observation of the housekeeping office revealed an electrical junction box without a cover in the ceiling. The Director of Engineering and the Lead Maintenance Technician witnessed and acknowledged this finding. <p>Actual reference:</p> <p>NFPA 101</p> <p>70.10.22 Identification of Disconnecting Means.</p> <p>Each disconnecting means shall be legibly</p>		<p><u>K 147</u></p> <p>Corrective action for residents found to have been affected by this deficiency:</p> <p>Circuit breaker devices have been labeled in the 500 hall</p> <p>Electric boxes have received covers in the dialysis water room and housekeeping office</p> <p>Corrective action for residents that may be affected by this deficiency:</p> <p>All residents have the potential to be affected by these identified concerns.</p> <p>Circuit breaker devices have been labeled in the 500 hall</p> <p>Electric boxes have received covers in the dialysis water room and housekeeping office</p> <p>Facility audit completed to ensure all other circuit breakers devices have been labeled and electric boxes covered</p> <p>In-service will be provided to Engineering staff regarding circuit breaker labeling and electric box coverings by 8/1/14</p> <p>Measures that will be put into place to ensure that this deficiency does not recur:</p> <p>Director of Engineering or Administrator will complete weekly audit for a period of at least 8 weeks to examine circuit breaker labels and 5 electric boxes each week. Any issues will be reported to the Safety Committee.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135007	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - ENTIRE NF B. WING _____		(X3) DATE SURVEY COMPLETED 06/30/2014
NAME OF PROVIDER OR SUPPLIER BINGHAM MEMORIAL SKILLED NURSING & R			STREET ADDRESS, CITY, STATE, ZIP CODE 98 POPLAR STREET BLACKFOOT, ID 83221		
(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 147	Continued From page 8	K 147			
	<p>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> <p>70 ARTICLE 314 Outlet, Device, Pull, and Junction Boxes; Conduit Bodies; Fittings; and Manholes</p> <p>II. Installation</p> <p>(C) Covers. All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding requirements of 250.110. An extension from the cover of an exposed box shall comply with 314.22, Exception.</p>		<p>Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that this deficiency has been corrected and will not recur:</p> <p>The Safety Committee will review any issues uncovered by weekly audits and after the initial 8 weeks make a determination related to changing the frequency of those audits. Additionally, Safety Committee will review facility progress on labeling circuit breakers and covering electric boxes on an on-going basis to aid in monitoring compliance.</p>	8/4/14	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135007	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE NF B. WING _____	(X3) DATE SURVEY COMPLETED 06/30/2014
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NAME OF PROVIDER OR SUPPLIER BINGHAM MEMORIAL SKILLED NURSING & REHA	STREET ADDRESS, CITY, STATE, ZIP CODE 98 POPLAR STREET BLACKFOOT, ID 83221
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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 (III) structure with a two hour fire wall to the JCAHO accredited hospital. The facility was originally built in 1963 with renovation and addition in 1999. The building is fully sprinklered and is licensed for 70 beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on June 30, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70 in addition to IDAPA 16.03.02 RULES AND MINIMUM STANDARDS FOR SKILLED NURSING.</p> <p>The Survey was conducted by:</p> <p>Dan Holbrook Health Facility Surveyor Facility Fire Safety and Construction</p>	C 000	<p style="text-align: center;">RECEIVED JUL 23 2014 FACILITY STANDARDS</p> <p>Please see attached POC for K 012, K027, K029, K070, + K147</p>	
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. This RULE: is not met as evidenced by: Refer to the following K-tags on form 2567:</p> <p>K 12 Penetrations K 27 Corridor doors K 29 Hazardous area door</p>	C 226		

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

TITLE

(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135007	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE NF B. WING: _____	(X3) DATE SURVEY COMPLETED 06/30/2014
NAME OF PROVIDER OR SUPPLIER BINGHAM MEMORIAL SKILLED NURSING & REHA		STREET ADDRESS, CITY, STATE, ZIP CODE 98 POPLAR STREET BLACKFOOT, ID 83221		
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C 226	Continued From Page 1 K 70 Portable heater K 147 Electrical	C 226		

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.