



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7012 3050 0001 2128 3658

July 10, 2014

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

Provider #: 135136

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Borup:

On **July 1, 2014**, 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 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

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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 5, 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 5, 2014**. A change in the seriousness of the deficiencies on **August 5, 2014**, may result in a change in the remedy.

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

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August 5, 2014, includes the following:

Denial of payment for new admissions effective **October 1, 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 **January 1, 2015**, 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 **July 1, 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>

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[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,



Mark P. Grimes, Supervisor
Facility Fire Safety and Construction

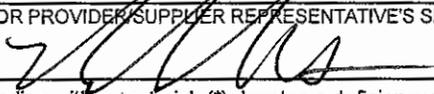
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Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135136	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/01/2014
NAME OF PROVIDER OR SUPPLIER QUINN MEADOWS REHABILITATION & CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1033 WEST QUINN ROAD POCATELLO, ID 83202		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	<p>INITIAL COMMENTS</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 July 1, 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 surveyor conducting the survey was:</p> <p>Dan Holbrook Health Facility Surveyor</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 or 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 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> <p>K-062 SS=D</p> <p><i>Corrective action a accomplished for those residents found to have been affected by the deficient practice:</i></p>	08/05/14
K 062 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25 9.7.5</p> <p>This Standard is not met as evidenced by: Based on observation the facility failed to maintain fire sprinkler systems. Failure to maintain fire sprinkler systems can result in delayed or failed operation allowing a fire to grow. This deficiency affected one resident, staff, and visitors. The facility is licensed for 41 beds and had a census of 37 the day of survey.</p>	K 062	<p>All residents, staff and visitors had the potential to be affected by this practice. The sprinkler head in room #111 and sprinkler heads throughout the building are scheduled to be assessed and repaired on 07/21/2014 to ensure proper placement of all affected sprinkler heads.</p> <p><i>Identification of other residents having the same potential to be affected by the same practice and what corrective action(s) taken include the following:</i></p>	

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

TITLE

(X6) DATE



ADMINISTRATOR

7/21/14

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 062	Continued From page 1 Findings include: 1. Observation of resident room #111 on July 1, 2014 revealed one sprinkler head had dropped approximately 1/2 inch creating a hole in the ceiling. The Maintenance Engineer witnessed and acknowledged this finding. 2. Observation on July 1, 2014 during the hours of 10:22 am and 11:30 am revealed uncounted widespread sprinkler heads throughout the building which were not in the original position of installation. The Maintenance Engineer witnessed and acknowledged this finding. Actual NFPA reference: NFPA 25 2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9.	K 062	All residents, staff and visitors had the potential to be affected by this practice. The sprinkler heads throughout the building are scheduled to be assessed and repaired on 07/21/2014 to ensure proper placement of all affected sprinkler heads. Measure that will be put in place or systemic you will make to ensure that the deficient practice does not recur includes the following: A quarterly "visual inspection form" has been implemented to inspect all sprinkler heads within the facility are properly positioned and repaired as needed. How the corrective action(s) will be monitored to ensure the deficient practice will not recur monitoring will be done by the following: The Maintenance Director or designee will do quarterly inspections on all sprinkler heads throughout the facility to ensure that all sprinkler heads are properly positioned. This will be noted on the "visual inspection form" The Administrator/designee will review the "visual inspection form" quarterly. Results will be discussed during the Quarterly Q A & A Committee meeting and continuation or discontinue will be assessed during that meeting.	

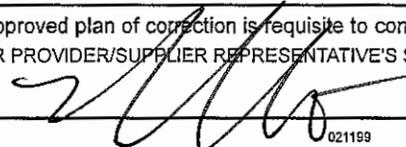
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C 000	<p>16.03.02 INITIAL COMMENTS</p> <p>The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.</p> <p>The facility is approximately 26,000 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 July 1, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR, 483.70 and 16.03.02 - RULES AND MINIMUM STANDARDS FOR SKILLED NURSING AND INTERMEDIATE CARE FACILITIES</p> <p>The surveyor conducting the survey was:</p> <p>Dan Holbrook Health Facility Surveyor</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 or 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 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> <div style="text-align: center;">  <p>JUL 23 2014</p> <p>FACILITY STANDARDS</p> </div>	
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-tag on form 2567:</p>	C 226	SEE Tag K-062	08/05/14

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

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C 226	Continued From Page 1 K 62 Fire sprinklers	C 226		

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