



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" DTTER -- 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 3498

July 31, 2014

Rod Jacobson, Administrator
Bear Lake Memorial Skilled Nursing Facility
164 South Fifth Street
Montpelier, ID 83254-1557

Provider #: 135070

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Jacobson:

On **July 22, 2014**, a Facility Fire Safety and Construction survey was conducted at **Bear Lake Memorial Skilled Nursing Facility** 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

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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 **August 13, 2014**. Failure to submit an acceptable PoC by **August 13, 2014**, may result in the imposition of civil monetary penalties by **September 2, 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 26, 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 26, 2014**. A change in the seriousness of the deficiencies on **August 26, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **August 26, 2014**, includes the following:

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Denial of payment for new admissions effective **October 22, 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 22, 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 22, 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/NursingFacilities/tabid/434/Default.aspx>

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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 **August 13, 2014**. If your request for informal dispute resolution is received after **August 13, 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

MPG/lj
Enclosures

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

Printed: 07/30/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135070	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/22/2014
NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL SKILLED NURSING F		STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH 5TH STREET MONTPELIER, ID 83254	
(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)
K 000	<p>INITIAL COMMENTS</p> <p>The facility is a single story type V (111) construction, fully sprinklered and built in 1977. It is separated from the existing hospital by a two hour fire separation. The nursing facility has two smoke compartments. The facility is currently licensed for 36 SNF/NF beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on July 22, 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>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	K 000	<p style="text-align: center;">RECEIVED SEP 02 2014 FACILITY STANDARDS</p>
K 029 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour 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</p> <p>This Standard is not met as evidenced by: Based on observation, operational testing and interview, the facility failed to ensure hazardous</p>	K 029	

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

TITLE

(X6) DATE

Robney Jacobs

Admin

8-12-14

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 029	<p>Continued From page 1</p> <p>areas were protected with a self-closing door. Failure to provide self-closing doors to hazardous areas would result in the passage of smoke and dangerous gases between smoke compartments during a fire. This deficient practice affected 20 residents, staff and visitors in 1 of 2 smoke compartments on the date of the survey. The facility is licensed for 36 SNF/NF beds and had a census of 30 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on July 22, 2014 from 3:30 PM to 3:45 PM, observation and operational testing of the storage room door abutting the Clean Utility room demonstrated it would not self-close. Further observation revealed the storage room was approximately 80 square feet in size. When asked, the Maintenance Director indicated the self-closure was recently installed and he was not aware the door was not closing.</p> <p>Actual NFPA standard:</p> <p>19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. 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: (1) Boiler and fuel-fired heater rooms</p>	K 029	<p>The alleged deficiency K029 is regarding the storage room door not self-closing which has the potential for smoke and gases to pass through it during a fire. This deficiency will be repaired by our maintenance supervisor so the self-closure door works by 08/20/15. The failure of the door to close has the potential to affect 36 residents, staff and visitors. Additionally the Maintenance Supervisor will perform a physical inventory of all doors in the SNF to ensure they have self-closing devices and they are functioning properly. This inventory will be completed by 08/20/14. The maintenance department will monitor the self-closing doors for a 6 month period with documentation of the findings.</p>

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K 029	Continued From page 2 (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. 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.	K 029		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This Standard is not met as evidenced by: Based on observation and interview, the facility	K 056		

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K 056	<p>Continued From page 3</p> <p>failed to ensure that overhangs greater than four feet in depth were protected as required under NFPA 13. Failure to provide suppression coverage of overhangs would result in an uncontrolled fire spreading into the facility. This deficient practice affected all residents, staff and visitors using the southeast exit on the date of the survey. The facility is licensed for 36 SNF/NF beds and had a census of 30 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the facility tour conducted on July 22, 2014 from 3:45 PM to 4:30 PM, observation of the southeast exit revealed a five foot wide, fifty foot long overhang which was unsprinklered. Interview of the Maintenance Director revealed this overhang was created to prevent ice from building up along the exit walk during winter months. This finding was further acknowledged by the CFO during the exit conference conducted on July 22, 2014 from 4:45 PM to 5:30 PM.</p> <p>2) During the facility tour conducted on July 22, 2014 from 3:45 PM to 4:30 PM, observation of the overhang on the east side of the building revealed a six foot by five foot section without sprinklers. Interview of the Maintenance Director revealed he was not aware of this section being unsprinklered.</p> <p>Actual NFPA standard:</p> <p>5-13.8* Exterior Roofs or Canopies. 5-13.8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or</p>	K 056	<p>The alleged deficiency K056 refers to the overhang on the east side of the SNF building. This overhang was built in 2006 to prevent ice build-up on the stairs. The original design did not have a fire sprinkler included. This deficiency has the potential to affect all 36 residents, staff and visitors using the southeast exit of the facility. The SNF will contract with a licensed Fire Sprinkler contractor to install an approved sprinkler system in this overhang. The date of completion will be 09/15/14.</p> <p>The Maintenance Supervisor will be responsible to arrange the contract with the contractor and to oversee the completion of the project.</p> <p>With any plans for future construction the maintenance supervisor will be responsible to assure sprinklers are included where they are required.</p>	

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NAME OF PROVIDER OR SUPPLIER EAR LAKE MEMORIAL SKILLED NURSING F	STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH 5TH STREET MONTPELIER, ID 83254
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K 056	Continued From page 4 limited combustible construction.	K 056		
K 067 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>This Standard is not met as evidenced by: Based on record review and interview, the facility failed to complete 4-year interval testing on its dampers as required under NFPA 90A. Failure to ensure dampers will operate to manufacturer's specifications would allow smoke and dangerous gases to pass freely throughout the facility during a fire event. This deficient practice affected 30 residents, staff and visitors in 2 of 2 smoke compartments on the date of the survey. The facility is licensed for 36 SNF/NF beds and had a census of 30 on the day of the survey.</p> <p>Findings include:</p> <p>During record review conducted at the facility on July 22, 2014 from 9:15 AM to 11:00 AM, the facility failed to provide a 4-year interval testing report of its dampers. During interview, the Maintenance Director stated this testing had not been completed for both the Skilled Nursing section and/or the hospital.</p> <p>Actual NFPA standard:</p> <p>NFPA 90A 3-4.7 Maintenance. At least every 4 years, fusible links (where</p>	K 067	<p>The alleged deficiency K067 refers to a failure to perform a 4 year interval testing of dampers. This deficiency had the potential to affect 36 residents, staff and visitors in the event of a fire. The failure of dampers to operate would allow smoke and dangerous gases to pass throughout the facility. The plan of correction includes the Skilled Nursing Facility to contract with a licensed inspection contractor to perform the damper testing. SNF will contract with this company to do this inspection on a preventative basis every 4 years. The testing of the dampers will be completed by 09/15/14.</p> <p>The Maintenance Supervisor will be responsible to initiate and follow through with the contract agreements and completion of the testing. The MS will also monitor and document the testing and results every 4 years.</p>	

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K 067 Continued From page 5
applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary.

K 147 NFPA 101 LIFE SAFETY CODE STANDARD
SS=F
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 electrical installations were in accordance with NFPA 70. Failure to ensure proper electrical installations would result in electrocution or fire. This deficient practice affected 20 residents, staff and visitors in 1 of 2 smoke compartments on the date of the survey. The facility is licensed for 36 beds and had a census of 30 on the day of the survey.

Findings include:

During the facility tour conducted on July 22, 2014 from 3:30 PM to 3:45 PM, observation of the Clean Utility room abutting the smoke compartment doors revealed a four inch square electrical conduit box without the protective covering in place. Interview of the Maintenance Director indicated he was not aware this cover was missing.

Actual NFPA standard:

NFPA 70
NFPA 70
110.12 Mechanical Execution of Work.
Electrical equipment shall be installed in a neat and workmanlike manner.

K 067

K 147

The alleged deficiency K 147 refers to a missing cover plate which had the potential to affect 36 residents, staff and visitors. Failure to ensure proper electrical installations could result in electrocution or fire. The missing cover plate will be replaced by 08/14/14. A survey will be conducted by the maintenance supervisor throughout the SNF to assure no similar conditions exist by the same deadline as listed above. The maintenance supervisor will monitor and document his findings, checking all electrical conduit boxes for covers for the next 3 months.

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K 147	<p>Continued From page 6</p> <p>(A) Unused Openings. Unused cable or raceway openings in boxes, raceways, auxiliary gutters, cabinets, cutout boxes, meter socket enclosures, equipment cases, or housings shall be effectively closed to afford protection substantially equivalent to the wall of the equipment. Where metallic plugs or plates are used with nonmetallic enclosures, they shall be recessed at least 6 mm (¼ in.) from the outer surface of the enclosure.</p> <p>(B) Subsurface Enclosures. Conductors shall be racked to provide ready and safe access in underground and subsurface enclosures into which persons enter for installation and maintenance.</p> <p>(C) Integrity of Electrical Equipment and Connections. Internal parts of electrical equipment, including busbars, wiring terminals, insulators, and other surfaces, shall not be damaged or contaminated by foreign materials such as paint, plaster, cleaners, abrasives, or corrosive residues. There shall be no damaged parts that may adversely affect safe operation or mechanical strength of the equipment such as parts that are broken; bent; cut; or deteriorated by corrosion, chemical action, or overheating.</p> <p>314.17 Conductors Entering Boxes, Conduit Bodies, or Fittings. Conductors entering boxes, conduit bodies, or fittings shall be protected from abrasion and shall comply with 314.17(A) through (D).</p> <p>(A) Openings to Be Closed. Openings through which conductors enter shall be adequately closed.</p> <p>...</p>	K 147		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135070	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE NF B. WING _____	(X3) DATE SURVEY COMPLETED 07/22/2014
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NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL SKILLED NURSING FACIL	STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH 5TH STREET MONTPELIER, ID 83254
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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 (111) construction, fully sprinklered and built in 1977. It is separated from the existing hospital by a two hour fire separation. The nursing facility has two smoke compartments. The facility is currently licensed for 36 SNF/NF beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on July 22, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70 and IDAPA 16.03.02 Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities.</p> <p>The Survey was conducted by:</p> <p>Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction</p>	C 000	<p>REVISED PLAN OF CORRECTION</p> <p>08/27/14</p> <p style="text-align: center;">RECEIVED SEP 02 2014 FACILITY STANDARDS</p> <p>Refer to Federal form K tag correction plan.</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.</p> <p>This Rule is not met as evidenced by: Please refer to "K" tags on CMS 2567</p>	C 226		

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

Rodney Jacobs

TITLE

Admin

(X6) DATE

8-12-14

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER BEAR LAKE MEMORIAL SKILLED NURSING FACIL		STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH 5TH STREET MONTPELIER, ID 83254		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 226	Continued From Page 1 K 029 Hazardous areas K 056 Canopies requiring sprinklers K 067 Damper testing K 147 Electrical installation	C 226		