



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 3511**

October 10, 2014

Trent Alder, Administrator  
Franklin County Transitional Care  
44 North First East  
Preston, ID 83263-1326

Provider #: 135059

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

Dear Mr. Alder:

On **September 29, 2014**, a Facility Fire Safety and Construction survey was conducted at **Franklin County Transitional Care** 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 **October 23, 2014**. Failure to submit an acceptable PoC by **October 23, 2014**, may result in the imposition of civil monetary penalties by **November 11, 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 **November 3, 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 **November 3, 2014**. A change in the seriousness of the deficiencies on **November 3, 2014**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **November 3, 2014**, includes the following:

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Denial of payment for new admissions effective **December 29, 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 **March 29, 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 **September 29, 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 **October 23, 2014**. If your request for informal dispute resolution is received after **October 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

Mr. Mark Grimes,  
Supervisor Facility Fire Safety and Construction  
Department of Health and Welfare  
Bureau of Facility Standards  
P.O. Box 83720  
Boise, Idaho 83720-0009

October 21, 2014

**RECEIVED**

**OCT 24 2014**

Dear Mr. Grimes

**FACILITY STANDARDS**

This letter is in regards to the September 29<sup>th</sup> 2014 Fire Life Safety Survey and the Plan of Correction for the Medicare/Licensure Fire Life Safety Survey for the Franklin County Transitional Care.

Please find attached our Plan of Corrections

If you have any questions please contact me

Sincerely,

A handwritten signature in black ink, appearing to read "Trent Alder", with a long horizontal flourish extending to the right.

Trent Alder  
Administrator  
Franklin County Transitional Care.

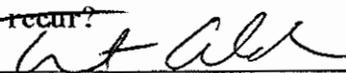
**PLAN OF CORRECTION FOR THE STATE OF IDAHO - FRANKLIN COUNTY MEDICAL CENTER - NURSING HOME**

Date of Survey: September-29-14

Opportunity to Correct: November 03, 2014

POC deadline: October 23, 2014

Criteria: Include dates when corrective action will be completed.

1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?
2. How will we identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken?
3. What measures will be put into place or what systemic changes we will make to ensure that the deficient practice does not recur?
4. How the corrective actions(s) will be monitored to ensure the deficient practice will not recur?
5. Date corrective action will be completed 10/23/14 Signature of Administrator 

TAG NUMBER	SCOPE/ SEVERITY	RESIDENT IDENTIFIERS	CRITERIA	FACILITY RESPONSE AND CORRECTIONS-
K 012	E			<b>Maintain smoke barriers</b>
			1.	The ceiling tile that had a hole in Telecommunications room has been replaced on 09-30-14 See attached picture.
			2.	All residents could be affected by this. See #3 for corrective action.
			3.	The Maintenance staff will continue <del>to</del> with monthly checks of all ceiling tiles to ensure that they are whole without holes.
			4.	The monthly checks will be documented and if ceiling tiles are found deficient they will be replaced. This will be reported to the Safety committee during their meetings and continue every month.
			5.	<b>COMPLETION DATE =10-23-2014</b>
K 029	E			<b>Self-closing Doors for Hazardous areas</b>
			1.	Maintenance has ordered and will install a new door closer for storage room adjacent to the Nurses Lounge.
			2.	All residents could be affected by this. See #3 for corrective action.
			3.	Maintenance staff will check monthly all hazardous areas to ensure that the doors to these areas are self-closing.
			4.	The monthly checks will be documented and if hazardous areas are found deficient the doors will be replaced. This will be reported to the Safety committee during their meetings.
			5.	<b>COMPLETION DATE =10-23-2014</b>
K 047	E			<b>Exit Sign Illumination</b>
			1.	The northeast exit at the front lobby has had installed a Energy Efficient Compact sign on 10-14-2014. See attached picture.
			2.	All residents could be affected by this. See #3 for corrective action.
			3.	Maintenance staff will check monthly all exit signs to ensure that the signs to these areas are illuminated.
			4.	The monthly checks will be documented and if exit signs are found deficient the bulbs/lights will be replaced. This will be reported to the Safety committee during their meetings.
			5.	<b>COMPLETION DATE = 10-23-2014</b>
K 75	F			<b>Highly combustible material stored in safe manner</b>

TAG NUMBER	SCOPE/ SEVERITY	RESIDENT IDENTIFIERS	CRITERIA	FACILITY RESPONSE AND CORRECTIONS-
			1.	The laundry hamper has been removed from the alcove areas on 10-07-2014. Only one hamper will be stored in the closet area. See attached picture.
			2.	All residents could be affected by this. See #3 for corrective action
			3.	Maintenance staff will check monthly to ensure that only one hamper is in the closet area.
			4.	The monthly checks will be documented and if hampers are found in wrong place they will be removed and staff informed. This will be reported to the Safety committee during their meetings.
			5.	<b>COMPLETION DATE =10-23-2014</b>
K 147	D			<b>Protective cover for electrical junction box</b>
			1.	A protective cover was installed on the junction box in the Dietary Services office on 10-10-2014. See attached picture.
			2.	All residents could be affected by this. See #3 for corrective action
			3.	Maintenance staff will check monthly to ensure that all electrical wiring and equipment will in code.
			4.	The monthly checks will be documented and if electrical wiring and equipment is not in code the wiring or equipment will be fixed or repaired. This will be reported to the Safety committee during their meetings.
			5.	<b>COMPLETION DATE =10-23-2014</b>
C 236				All K tags
			1,2,3,4	See K 012, K 029, K 047, K, 075, K 147
			5.	<b>COMPLETION DATE =10-23-201411</b>

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:  135059	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE NF BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  09/29/2014
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NAME OF PROVIDER OR SUPPLIER  FRANKLIN COUNTY TRANSITIONAL CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 44 NORTH FIRST EAST PRESTON, ID 83263
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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  The facility is a single story Type II (111) building with a complete sprinkler system that was installed in July 2012. The plans for the building were approved in 1970 and construction completed in 1971. There have been subsequent remodels. Currently the facility is licensed for 35 NF beds.  The following deficiencies were cited during the annual fire/life safety survey conducted on September 29, 2014. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Existing Health Care Occupancy, in accordance with 42 CFR 483.70.  The Survey was conducted by:  Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	K 000		
K 012 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  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  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to properly maintain smoke barriers. Failure to ensure smoke barriers are maintained would allow smoke and dangerous gases to pass freely between smoke compartments and hinder egress capabilities. This deficient practice affected residents, staff and visitors using the west exit	K 012		

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FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>W. A. Allen</i>	TITLE Administrator	(X6) DATE 10/21/14
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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.

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NAME OF PROVIDER OR SUPPLIER  FRANKLIN COUNTY TRANSITIONAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 44 NORTH FIRST EAST PRESTON, ID 83263	
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K 012	Continued From page 1 from the TCU wing on the date of the survey. The facility is licensed for 35 SNF/NF beds and had a census of 27 on the day of the survey.  Findings include:  During the facility tour conducted on September 29, 2014 from 1:30 PM to 4:00 PM, observation of the ceiling in telecommunications room located at the west exit into the hospital wing found a 4" diameter unsealed hole. When asked, the Maintenance Supervisor stated he believed the hole was a former duct pipe that had been removed.  Actual NFPA standard:  8.3.2* Continuity. Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. Exception: A smoke barrier required for an occupied space below an interstitial space shall not be required to extend through the interstitial space, provided that the construction assembly forming the bottom of the interstitial space provides resistance to the passage of smoke equal to that provided by the smoke barrier.	K 012		
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1	K 029		

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K 029	<p>Continued From page 2</p> <p>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 areas were protected with a self-closing door. Failure to provide a self-closing door to hazardous areas would allow smoke and dangerous gases to pass freely into corridors hindering egress capabilities. This deficient practice affected 10 residents, staff and visitors in 2 of 2 smoke compartments on the date of the survey. The facility is licensed for 35 SNF/NF beds and had a census of 27 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on September 29, 2014 from 1:00 PM to 3:00 PM, observation and operational testing of the door into the storage room adjacent to the Nurse's Lounge found it contained combustible storage and measured approximately ten feet by ten feet (100 square feet). When asked, the Maintenance Supervisor stated he was not aware this storage room required a self-closing door.</p> <p>During the exit conference conducted on</p>	K 029		

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K 029	<p>Continued From page 3</p> <p>September 29, 2014 from 3:00 PM to 4:00 PM, interview of staff found this storage room was recently converted and it was not known at that time the door was required to self-close.</p> <p>Actual NFPA standard:</p> <p>3.3.13.2 Area, Hazardous. An area of a structure or building that poses a degree of hazard greater than that normal to the general occupancy of the building or structure, such as areas used for the storage or use of combustibles or flammables; toxic, noxious, or corrosive materials; or heat-producing appliances.</p> <p>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:</p> <ol style="list-style-type: none"> <li>(1) Boiler and fuel-fired heater rooms</li> <li>(2) Central/bulk laundries larger than 100 ft<sup>2</sup> (9.3 m<sup>2</sup>)</li> <li>(3) Paint shops</li> <li>(4) Repair shops</li> <li>(5) Soiled linen rooms</li> <li>(6) Trash collection rooms</li> <li>(7) Rooms or spaces larger than 50 ft<sup>2</sup> (4.6 m<sup>2</sup>), including repair shops, used for storage of combustible supplies and equipment in quantities</li> </ol>	K 029		

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K 029	Continued From page 4 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 047 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure exit sign illumination was maintained. Failure to ensure proper illumination of exit signs would hinder safe egress from the facility during a fire or other emergency. This deficient practice affect residents, staff and visitors utilizing the main entrance/exit of the building. The facility is licensed for 35 SNF/NF beds and had a census of 27 on the day of the survey.  Findings include:  During the facility tour conducted on September 29, 2014 from 1:30 PM to 2:30 PM, observation of the main exit sign to the northeast exit at the front lobby found it had no illumination. Inquiry of	K 047		

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K 047	Continued From page 5 the Maintenance Supervisor found he was not aware the light was out. Investigation of this light by the Maintenance Supervisor revealed the bulbs of the sign were burnt out.  Actual NFPA standard:  19.2.10.1 Means of egress shall have signs in accordance with Section 7.10. Exception: Where the path of egress travel is obvious, signs shall not be required in one-story buildings with an occupant load of fewer than 30 persons.  7.10.5 Illumination of Signs. 7.10.5.1* General. Every sign required by 7.10.1.2 or 7.10.1.4, other than where operations or processes require low lighting levels, shall be suitably illuminated by a reliable light source. Externally and internally illuminated signs shall be legible in both the normal and emergency lighting mode.	K 047		
K 075 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5	K 075		

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K 075	Continued From page 6  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that highly combustible material was stored in a safe manner. Failure to provide proper protection of hazardous storage would result in smoke and dangerous gases passing freely into corridors during a fire and hindering egress capabilities. This deficient practice affected 27 residents, staff and visitors in 3 of 3 smoke compartments on the date of the survey. The facility is licensed for 35 SNF/NF beds and had a census of 27 on the day of the survey.  Findings include:  During the facility tour conducted on September 29, 2014 from 1:00 PM to 3:00 PM, observation of the hoier storage areas located in both the A and B wings found that both areas contained two (2) 32 gallon soiled and trash receptacles and were directly open to the main corridors. Interview of the Maintenance Supervisor found that he was not aware that these four (4) containers were required to be separated or contained in hazardous area storage.  Actual NFPA standard: 19.7.5.5 Soiled linen or trash collection receptacles shall not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gal/ft <sup>2</sup> (20.4 L/m <sup>2</sup> ). A capacity of 32 gal (121 L) shall not be exceeded within any 64-ft <sup>2</sup> (5.9-m <sup>2</sup> ) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) shall be	K 075		

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

PRINTED: 10/09/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135059</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - ENTIRE NF BUILDING</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/29/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>FRANKLIN COUNTY TRANSITIONAL CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>44 NORTH FIRST EAST PRESTON, ID 83263</b>		
(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 075	Continued From page 7 located in a room protected as a hazardous area when not attended. Exception: Container size and density shall not be limited in hazardous areas.	K 075			
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 that electrical installations were in accordance with NFPA 70. Failure to ensure proper installation of electrical wiring would result in electrocution or fire. This deficient practice affected no residents, staff and visitors in the Kitchen on the date of the survey. The facility is licensed for 35 SNF/NF beds and had a census of 27 on the day of the survey.  Findings include:  During the facility tour conducted on September 29, 2014 from 1:00 PM to 3:00 PM, observation of the Dietary Services office located in the main Kitchen found a junction box for the wiring to an installed wall heater had no protective cover and these wires were exposed. When asked, the Maintenance Supervisor stated he was not aware this cover was missing.  Actual NFPA standard:  NFPA 70 110.12 Mechanical Execution of Work. Electrical equipment shall be installed in a neat	K 147			

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K 147	Continued From page 8 and workmanlike manner. (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. (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. (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.	K 147		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MDS001210	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - ENTIRE NF BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  09/29/2014
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NAME OF PROVIDER OR SUPPLIER  
**FRANKLIN COUNTY TRANSITIONAL CARE**

STREET ADDRESS, CITY, STATE, ZIP CODE  
**44 NORTH FIRST EAST  
PRESTON, ID 83263**

(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 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 II (111) building with a complete sprinkler system that was installed in July 2012. The plans for the building were approved in 1970 and construction completed in 1971. There have been subsequent remodels. Currently the facility is licensed for 35 NF beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on September 29, 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		
C 236	<p>02.106.03,e Composition of Ashtrays</p> <p>e. That noncombustible ashtrays of a safe design shall be provided in all areas where smoking is permitted. This Rule is not met as evidenced by: Please refer to K tags on federal form CMS 2567:</p> <p>K 012 Smoke compartment continuity K 029 Hazardous area doors</p>	C 236		

RECEIVED  
OCT 24 2014  
FACILITY STANDARDS

Bureau of Facility Standards  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Tom Aldrich* TITLE *Administrative* (X6) DATE *10/21/14*

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MDS001210</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: <b>01 - ENTIRE NF BUILDING</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/29/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>FRANKLIN COUNTY TRANSITIONAL CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>44 NORTH FIRST EAST PRESTON, ID 83263</b>
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C 236	Continued From page 1  K 047 Exit sign illumination K 075 Combustible material storage K 147 Electrical wiring	C 236		