



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 3603**

November 14, 2014

Darwin Royeca, Administrator  
Lincoln County Care Center  
511 East Fourth Street Po Box 830  
Shoshone, ID 83352-1502

Provider #: 135056

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

Dear Mr. Royeca:

On **October 29, 2014**, a Facility Fire Safety and Construction survey was conducted at **Lincoln County Care Center** by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies and a similar State Form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide **ONLY ONE** completion date for each federal and state tag in column (X5) Completion Date to signify when you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date

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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 **November 27, 2014**. Failure to submit an acceptable PoC by **November 27, 2014**, may result in the imposition of civil monetary penalties by **December 16, 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 **December 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 **December 3, 2014**. A change in the seriousness of the deficiencies on **December 3, 2014**, may result in a change in the remedy.

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

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Denial of payment for new admissions effective **January 29, 2015**.  
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 **April 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 **October 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:

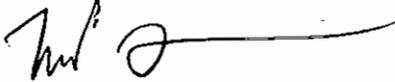
BFS Letters (06/30/11)

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

This request must be received by **November 27, 2014**. If your request for informal dispute resolution is received after **November 27, 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 'Mark P. Grimes', with a long horizontal flourish 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:  <b>135056</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ENTIRE BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/29/2014</b>
NAME OF PROVIDER OR SUPPLIER <b>LINCOLN COUNTY CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>511 EAST 4TH STREET SHOSHONE, ID 83352</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 018	<p>Continued From page 1 in all health care facilities.</p> <p>This Standard is not met as evidenced by: Based on observation it was determined that the facility did not ensure that there is no impediment to the closing of the doors protecting hazardous areas. Failure to provide effective self closing doors can allow smoke and fire gases to spread beyond the hazardous areas in the event of a fire. This condition affects approximately 5 staff members.</p> <p>Findings include:</p> <p>During the tour of the facility on October 29, 2014, at approximately 10:30 AM, observation revealed that a storage room was being converted in a new employee break room requiring the door to be self closing. This room measured greater then 50 square feet and contained combustible central supplies and training supplies. When this deficient practice was discussed with the administrator stated that he did not know that the door could not have any impediments to closing.</p> <p>Actual NFPA Standard: NFPA 101.19.3.6.3.1 Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick,</p>	K 018	<p>Maintenance director check the functionality of the door closer and made sure that there is no more impediment to the closing of the door by moving the locker to the side and made sure that there is no more obstruction to the door closing.</p> <p>All residents and staff have the potential to be affected by this practice.</p> <p>Staff were in serviced on Life Safety Code Citation and deficient practice. All staff taking a break in the break room will assure that the door is not propped open and will remain close at all times.</p> <p>Survey Citations and plan of correction was discussed on Monthly CQI meeting on November 12, 2014.</p> <p>Please see Exhibit.</p>	11/12/14

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K 018	Continued From page 2 solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.	K 018	Maintenance Director will complete one Break Room door inspection and audit weekly to ensure that break room door is unobstructed from self closing. Administrator will sign the completed weekly inspection and Audit.  Audits and Inspections will start on November 3, 2014.  All audits will be reviewed at monthly CQI meeting.	
K 029 SS=F	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 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 the facility failed to protect hazardous areas with self closing doors and smoke resistive partitions. Failure to protect	K 029	K029  NFPA 101 LIFE SAFETY CODE STANDARD  The facility will ensure to protect hazardous areas with self closing doors and smoke resistive partition.  On November 10, 2014 the Maintenance director installed a door closer on the tray door in the kitchen.	11/2/14

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K 029	<p>Continued From page 3</p> <p>hazardous areas may expose the facility to products of combustion in event of fire. This deficient practice affects all residents, staff, and visitors. The facility is licensed for 36 SNF beds and had a census of 28 the day of survey.</p> <p>Findings include:</p> <p>During the tour of the facility on October 29, 2014 at approximately 11:00 am, observation of the tray door in the kitchen area was not on a self closure. When this deficient practice was discussed with the administrator he was unaware that the door had to be self closing.</p> <p>Actual NFPA reference 101. 9.3.2.1 Hazardous Areas.</p> <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"> <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	<p>All residents and staff have the potential to be affected by this practice.</p> <p>Staff were in serviced on Life Safety Code Citation and deficient practice. All staff using the tray door will assure that the door is close at all times after each use.</p> <p>Survey Citations and plan of correction was discussed on Monthly CQI meeting on November 12, 2014.</p> <p>Please see Exhibit.</p> <p>Maintenance Director will complete a weekly Tray door inspection and audit to ensure that Tray door is close when not in use and the door closer is in good working condition. Administrator will sign the completed weekly inspection and Audit.</p> <p>Audits and Inspections will start on November 10, 2014.</p> <p>All audits will be reviewed at monthly CQI meeting.</p>	



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K 038	Continued From page 5 approximately 10:45 am revealed exit access leading from the TV Lobby area out through exit #6 was blocked by folding privacy curtains. The administrator acknowledged the finding at the exit interview.  Actual NFPA standard:  19.2.2.2.1 Doors complying with 7.2.1 shall be permitted.  7.2.1.1.2 Every door and every principal entrance that is required to serve as an exit shall be designed and constructed so that the path of egress travel is obvious and direct.  7.1.10.2.1 No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress therefrom, or visibility thereof.	K 038	Staff were in serviced on Life Safety Code Citation and deficient practice. All staff Using the folding privacy divider or curtain will assure to keep and store the folding privacy divider or curtain in the designated area.  Survey Citations and plan of correction was discussed on Monthly CQI meeting on November 12, 2014.  Please see Exhibit.  Maintenance Director will complete inspection and audit weekly to ensure a clear and unobstructed vision of exit doors. Administrator will sign the completed weekly inspection and Audit.  Audits and Inspections will start on November 3, 2014.  All audits will be reviewed at monthly CQI 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 a single story, type V(111) construction built in 1958. It is fully sprinklered building with smoke detection coverage in the hallways and open areas. Also quick response sprinklers are installed in the new entrance and the new addition of the dining room and most sprinkler heads date to the 70's. There is a partial basement. Currently the facility is licensed for 36 beds with a census of 28 on day of survey.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on October 29, 2014. The facility was surveyed under IDAPA 16.03.02, Rules, and Minimum Standards for Skilled Nursing and Intermediate Care Facilities.</p> <p>Nathan Elkins Health Facility Surveyor</p> <p>Mark Grimes, Supervisor Facility Fire Safety and Construction</p>	C 000	<p>RECEIVED NOV 25 2014 FACILITY STANDARDS</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 Federal "K" tags on the</p>	C 226		<p>Please refer to tag K018</p> <p>Please refer to tag K029</p> <p>Please refer to tag K038</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Darwin J. Boyce TITLE: Administrator (X6) DATE: 11/24/14

STATE FORM 021199 Z2J821 If continuation sheet 1 of 2

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C 226	Continued From Page 1  CMS - 2567:  1. K018 Doors.  2. K029 Hazardous Areas  3. K038 Exits and Egress	C 226			

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