



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 1010 0002 0836 4148**

November 13, 2013

Stephen Farnsworth, Administrator  
Pocatello Care & Rehabilitation Center  
527 Memorial Drive  
Pocatello, ID 83201-4063

Provider #: 135011

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

Dear Mr. Farnsworth:

On **November 6, 2013**, a Facility Fire Safety and Construction survey was conducted at **Pocatello Care & Rehabilitation 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 26, 2013**. Failure to submit an acceptable PoC by **November 26, 2013**, may result in the imposition of civil monetary penalties by **December 16, 2013**.

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 11, 2013**, (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 11, 2013**. A change in the seriousness of the deficiencies on **December 11, 2013**, may result in a change in the remedy.

The remedy, which will be recommended if substantial compliance has not been achieved by **December 11, 2013**, includes the following:

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Denial of payment for new admissions effective **February 6, 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 **May 6, 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 **November 6, 2013**, 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:

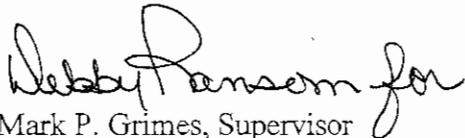
BFS Letters (06/30/11)

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

This request must be received by **November 26, 2013**. If your request for informal dispute resolution is received after **November 26, 2013**, 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: 11/13/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135011</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/06/2013</b>
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NAME OF PROVIDER OR SUPPLIER <b>POCATELLO CARE &amp; REHABILITATION CENT</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>527 MEMORIAL DRIVE POCATELLO, ID 83201</b>
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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
K 000	<p><b>INITIAL COMMENTS</b></p> <p>The facility is a Type II (222) multi-level structure built into a sloping hillside with multiple exits, four of the exits are to grade. The existing building was built in October 1963 and an addition in 1988. It is fully sprinklered with smoke detection throughout. Currently the facility is licensed for 88 SNF/NF beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on November 6, 2013. 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>Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This Standard is not met as evidenced by: Based on observation and interview, it was determined that the facility had not ensured exit doors are arranged to be opened readily from the egress side. Failure to provide accessible exits can slow or prevent egress to a public way. The facility had a census of fifty two residents on the day of the survey. This deficiency affected no residents and two staff members in one of six</p>	K 000	<p><i>See Attached POC</i></p> <p><b>RECEIVED</b></p> <p><b>NOV 27 2013</b></p> <p><b>FACILITY STANDARDS</b></p>	
K 038 SS=D	<p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This Standard is not met as evidenced by: Based on observation and interview, it was determined that the facility had not ensured exit doors are arranged to be opened readily from the egress side. Failure to provide accessible exits can slow or prevent egress to a public way. The facility had a census of fifty two residents on the day of the survey. This deficiency affected no residents and two staff members in one of six</p>	K 038		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Executive Director* (X6) DATE *11-25-13*

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 <b>POCATELLO CARE &amp; REHABILITATION CENT</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>527 MEMORIAL DRIVE POCATELLO, ID 83201</b>		
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K 038	Continued From page 1 smoke compartments.  Findings include:  During a tour of the facility on November 6, 2013 at 1:08 PM, observation of the employee break room door revealed that the door was equipped with a key operated deadbolt on the corridor side of the door. Further observation of the door revealed that the location of the lock on the room side of the door was covered with a metal plate preventing access to the working mechanisms for locking or unlocking the door. When this deficiency was discussed with the Maintenance and Housekeeping supervisors they acknowledged that the lock was only operable from the corridor side of the door.  Actual NFPA Standard:  NFPA 101® Life Safety Code ® 2000 Edition 19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7.  7.2.1.5.1 Doors shall be arranged to be opened readily from the egress side whenever the building is occupied. Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side.	K 038	<i>See Attached POC</i>	
K 043 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Patient room doors are arranged so that the patient can open the door from inside without using a key. (Special door locking arrangements are permitted in mental health facilities.) 19.2.2.2	K 043		

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K 043	<p>Continued From page 2</p> <p>This Standard is not met as evidenced by: Based on observation and interview, it was determined that the facility had not ensured that patient sleeping room doors were not equipped with locks. This deficiency can entrap people and prevent egress in the event of a fire or other emergency requiring immediate egress. The facility had a census of fifty two residents on the day of the survey. This deficiency affected twenty nine residents and eleven staff members in three of six smoke compartments.</p> <p>Findings include:</p> <p>During a tour of the facility on November 6, 2013 between 12:45 PM and 1:30 PM, observation of the C and D wings revealed that sleeping room doors were equipped with keyed deadbolt locks that are only operable from the corridor side. Observation of the room side of the doors revealed that the location of the locking mechanisms were covered with metal plates on the doors. The sleeping rooms observed were as follows: Room C48, 49, 52, 53, 54, 55, 59, 60, 64, 65, 68, 69, 70, and D rooms 72 to 97. When this deficiency was discussed with the Maintenance and Housekeeping Supervisors they acknowledged that the sleeping room doors were equipped with locks and were only operable from the corridor side of the door.</p> <p>Actual NFPA Standard:</p> <p>NFPA 101® Life Safety Code ® 2000 Edition 19.2.2.2.2 Locks shall not be permitted on patient sleeping room doors.</p>	K 043	<p><i>See Attached Fee</i></p>	

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K 043	Continued From page 3 Exception No. 1: Key-locking devices that restrict access to the room from the corridor and that are operable only by staff from the corridor side shall be permitted. Such devices shall not restrict egress from the room. Exception No. 2: Door-locking arrangements shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that keys are carried by staff at all times.	K 043		
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 did not ensure that the sprinkler system was installed in accordance with NFPA 13. Unprotected areas can allow a fire to grow, accelerate and spread. The facility had a census of fifty two residents on the day of survey. This deficiency affected twenty nine residents and eleven staff members in three of six smoke compartments.	K 056	<i>See Attached POC</i>	

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K 056	<p>Continued From page 4</p> <p>Findings include:</p> <p>During the tour of the facility on November 6, 2013 between the hours of 12:45 PM and 1:30 PM, observation of the closets in the resident rooms of C and D wings revealed that the interior of the closets were not provided with automatic fire sprinkler protection. When the deficient practice was discussed with the Surveyor, the Maintenance Supervisor stated that he had not noticed that the closets were not provided with sprinkler protection.</p> <p>Actual NFPA Standard:</p> <p>NFPA 13 Standard for the Installation of Sprinkler Systems 1999 Edition 5-1.1*</p> <p>The requirements for spacing, location, and position of sprinklers shall be based on the following principles:</p> <ol style="list-style-type: none"> <li>(1) Sprinklers installed throughout the premises</li> <li>(2) Sprinklers located so as not to exceed maximum protection area per sprinkler</li> <li>(3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution</li> </ol>	K 056	<p><i>See Attached pcc</i></p>	
K 069 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96</p> <p>This Standard is not met as evidenced by: Based on record review and interview it was determined that the facility did not ensure that the kitchen hood was being maintained in accordance with NFPA 96. Maintaining the hood helps to ensure the automatic fire suppression</p>	K 069		

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K 069	<p>Continued From page 5</p> <p>system functions as designed. The facility had a census of fifty two residents on the day of survey. This deficiency affected no residents or staff members.</p> <p>Findings include:</p> <p>During record review on November 6, 2013 at 9:25 AM, it was revealed that the last south kitchen automatic fire suppression system inspection report dated October 7, 2013, indicated that the cylinder hydrostatic test date was in 2000. When questioned about the overdue cylinder hydrostatic test the Maintenance Supervisor stated that he did not know that hydrostatic testing was due to be completed every twelve years.</p> <p>Actual NFPA Standard:</p> <p>NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations 2001 Edition</p> <p>10.2.6 Automatic fire-extinguishing systems shall be installed in accordance with the terms of their listing, the manufacturer ' s instructions, and the following standards where applicable.</p> <p>(1) NFPA 12, Standard on Carbon Dioxide Extinguishing Systems (2) NFPA 13, Standard for the Installation of Sprinkler Systems (3) NFPA 17, Standard for Dry Chemical Extinguishing Systems (4) NFPA 17A, Standard for Wet Chemical Extinguishing Systems</p> <p>NFPA 17A Standard for Wet Chemical Extinguishing Systems 1998 Edition 5-5* Hydrostatic Testing.</p>	K 069	<p><i>See Attached POC</i></p>	

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K 069	Continued From page 6 The following parts of wet chemical extinguishing systems shall be subjected to a hydrostatic pressure test at intervals not exceeding 12 years: (a) Wet chemical containers (b) Auxilliary pressure containers (c) Hose assemblies	K 069	<i>see Attached POC</i>	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135011</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - ENTIRE BUILDING</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/06/2013</b>
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NAME OF PROVIDER OR SUPPLIER <b>POCATELLO CARE &amp; REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>527 MEMORIAL DRIVE POCATELLO, ID 83201</b>
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C 000	<p><b>16.03.02 INITIAL COMMENTS</b></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 Type II (222) multi-level structure built into a sloping hillside with multiple exits, four of the exits are to grade. The existing building was built in October 1963 and an addition in 1988. It is fully sprinklered with smoke detection throughout. Currently the facility is licensed for 88 SNF/NF beds.</p> <p>The following deficiencies were cited during the annual fire/life safety survey conducted on November 6, 2013. The facility was surveyed under IDAPA 16.03.02, Rules and Minimum Standards for Skilled Nursing and Intermediate Care Facilities.</p> <p>The surveyor conducting the survey was:</p> <p>Taylor Barkley Health Facility Surveyor Facility Fire Safety and Construction</p>	C 000	<p><i>See Attached POC</i></p> <p><b>RECEIVED</b></p> <p><b>NOV 27 2013</b></p> <p><b>FACILITY STANDARDS</b></p>	
C 226	<p><b>02.106 FIRE AND LIFE SAFETY</b></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: Refer to the following Federal "K" tags on the CMS - 2567:</p>	C 226		

Idaho form

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

TITLE

(X6) DATE

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>135011</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - ENTIRE BUILDING</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/06/2013</b>
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C 226	<p>Continued From Page 1</p> <ol style="list-style-type: none"> <li>1. K038 Exit access.</li> <li>2. K043 Sleeping room door locks.</li> <li>3. K056 Automatic fire sprinkler system installation.</li> <li>4. K069 Hydrostatic testing.</li> </ol>	C 226	<p><i>See Attached POC</i></p>	

K-38 /C-226 "Egress in facility staff break room"

1. Parts and hardware for stainless steel door repair caps were ordered on 11/19/2013 by Plant Operations Manager. To be installed after key operated deadbolt and tumblers are removed from the door.
2. This deficiency affected no residents and has the potential to affect all staff members.
3. Plant Operations Manager to install the stainless steel door repair caps on the affected door after the key operated deadbolt and tumblers are removed.
4. Monthly door operation audits to be conducted by Plant Operations Manager X three months. Audits will begin on 11/27/2013 Results to be reported to Safety Committee and QA monthly for three months.
5. DOC- 12/10/2013

K-43/C-226 "Egress in resident rooms"

1. Parts and hardware for stainless steel door repair caps were ordered on 11/19/2013 by Plant Operations Manager. To be installed after key operated deadbolts and tumblers are removed from the residents doors.
2. This deficiency affected 29 residents and 11 staff members.
3. Plant Operations Manager will install the stainless steel door repair caps on the affected resident doors after the key operated deadbolts and tumblers are removed.
4. Monthly door operation audits to be conducted on affected resident rooms by Plant Operations Manager X three months. Audits to begin on 11/27/2013. Results to be reported to Safety Committee and QA monthly for three months.
5. DOC- 12/10/2013

K-56/C-226 "Fire sprinklers in resident closets"

1. Facility contacted certified Fire Safety contracted on 11/18/2013 to obtain a bid on the installation of proper fire sprinklers in the affected residents rooms.
2. This deficiency affected 29 residents and 11 staff members.
3. Install proper fire sprinklers and to modify the existing fire sprinkler system to add up to 54 new sprinkler heads to protect affected resident closets. Upper shelves will also be removed to ensure proper sprinkler coverage.
4. Plant Operations Manager to conduct monthly closet sprinkler head audits to ensure installed sprinkler heads are not obstructed. These audits will be conducted for duration of three months and findings will be reported to Safety Committee and QA monthly for three months.
5. DOC Extension Requested to 1/30/2014

K- 69/C-226 "Kitchen Hood Fire Suppression System"

1. Facility contacted a certified fire systems contractor on 11/18/2013 for a bid to install the appropriate fire suppression system.
2. This deficiency affected no residents and no staff.
3. Facility to have installed the appropriate hood fire suppression system by certified fire safety contractor according to the latest federal standards. ANSUL fire suppression system was installed and inspected by the Pocatello City Fire Marshal and approved on 11/22/2013.
4. Plant Operations Manager to conduct monthly charge inspection audits on the hood suppression system for three months. Findings to be reported to Safety Committee and QA monthly for three months.
5. DOC- 12/10/2013